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TABLE OF CONTENTS

1. INTRODUCTION.....	5
2. EXECUTIVE SUMMARY.....	6
2.1. Roadmap.....	6
2.2. Exchange Design Options	6
2.3. Communication Plan	7
2.4. Financial Sustainability	7
2.5. Financial Analysis	8
2.6. Conclusion.....	8
3. ROADMAP.....	9
3.1. Goals for the Alaska Exchange and Value Proposition.....	9
3.2. Key Policy Decisions	10
3.2.1. Governance and Administration	10
3.2.2. Eligibility Determination Process.....	12
3.2.3. Stakeholder Engagement	14
3.2.4. Outreach, Education and Enrollment.....	15
3.2.5. Web Portal.....	16
3.2.6. Essential Health Benefits Determination.....	18
3.2.7. Health Plan Selection and Management.....	19
3.2.8. Customer Service and Consumer Assistance	21
3.2.9. Financial Sustainability.....	22
3.3. Implementation Plan and Timeline	23
3.3.1. State Exchange.....	24
3.3.2. Federal Partnership Options	27
3.3.3. Limited Time Partnership	30
3.3.4. Federally Facilitated Exchange.....	31
3.4. Blueprint for Approval of State-Based and State Partnership Exchange	32
3.5. Summary of Additional Recommended Analyses.....	33
4. EXCHANGE DESIGN OPTIONS	36
4.1. Administration Options	36
4.1.1. Statewide, State-administered Exchange	36
4.1.2. Federally Facilitated Exchange.....	36
4.1.3. State and Federal Partnership Models	38

4.2. Governance Models.....	41
4.2.1. Governance Options	41
4.3. Actuarial Analysis	44
4.4. Program Integration.....	44
4.4.2. Navigator Program.....	49
4.4.3. Participating Health Carriers	50
4.4.4. Essential Health Benefits.....	52
4.4.5. Provider Networks.....	54
5. COMMUNICATION PLAN.....	56
5.1. Objectives	56
5.2. Stakeholder Identification	57
5.3. Two-Way Communication Strategy.....	58
5.3.1. Dissemination of Information from the State	58
5.3.2. Collection of Input from Stakeholders	58
5.4. Strategy for Managing Project Communications	59
5.5. Incorporation of Stakeholder Input into Planning Process	60
6. FINANCIAL SUSTAINABILITY.....	61
6.1. Revenue Options	61
6.2. Potential Revenue Summary Chart.....	64
6.3. Revenue Options Analysis	64
6.3.1. Qualified Health Plan Administrative Fees	64
6.3.2. Consumer Administrative Fees.....	66
6.3.3. Accreditation Fees to Agents and Brokers.....	67
6.3.4. Advertising.....	68
6.3.5. Commercial Partnerships for Direct Marketing.....	69
6.3.6. Administrative Fees to the Reinsurance Entity.....	71
6.3.7. Industry Wide Assessment.....	72
6.3.8. Insurance Plan Market Wide Assessment	73
6.4. Recommendations	74
7. FINANCIAL ANALYSIS.....	76
7.1. Introduction	76
7.2. Necessary Exchange Functions and Budget Estimates	76
7.2.1. Full Time Employee Salary and Benefits.....	78
7.2.2. Enrollment and Eligibility System	80

7.2.3.	Call Center	82
7.2.4.	Premium Billing and Website	84
7.2.5.	Other Contracted/Consulting Services	85
7.2.6.	General Administrative Costs.....	86
7.2.7.	Summary of Alaska Exchange Cost at 77,000 Enrollment Estimate.....	87
7.2.8.	Analysis of Exchange Costs Showing Enrollment at Differing Enrollment Totals	88

Tables

Table 1:	Implementation Plans for Governance Options	24
Table 2:	Implementation Plans for Federal Partnership Options	28
Table 3:	Implementation Plan for Limited Time Partnership Option	30
Table 4:	Implementation Plan for Federally Facilitate Exchange Option.....	31
Table 5:	State Agency Roles in the Exchange	44
Table 6:	Draft Educational Outreach Plan	58
Table 7:	Communication Matrix.....	59
Table 8:	Exchange Revenue Options	61
Table 9:	Potential Revenue Summary Chart.....	64
Table 10:	Potential QHP Administrative Revenue	65
Table 11:	Risks for QHP Administrative Fees.....	65
Table 12:	Risks for Consumer Administrative Fees	66
Table 13:	Risks for Agent and Broker Accreditation Fees	67
Table 14:	Risks for Advertising Revenue	69
Table 15:	Potential Revenue for Commercial Partnership for Direct Marketing	70
Table 16:	Risks for Commercial Partnership for Direct Marketing.....	70
Table 17:	Potential Risks for Reinsurance Entity Administrative Fees	72
Table 18:	Potential Risks for Industry Wide Assessment.....	73
Table 19:	Potential Risks for Insurance Plan Market Wide Assessment	74
Table 20:	Estimate of Salary and Benefits for Exchange Staff.....	79
Table 21:	Estimate for Enrollment and Eligibility System Options.....	81
Table 22:	Call Center Variable Factors.....	83
Table 23:	Estimate of Exchange Web Portal Costs	84
Table 24:	Estimate of General Administrative Costs.....	86
Table 25:	Summary of Exchange Cost at 77,000 Enrollment.....	87
Table 26:	Fixed vs. Variable Cost Allocations	88
Table 27:	Exchange Costs with 38,500 Enrollees.....	89
Table 28:	Exchange Costs with 115,500 Enrollees.....	90

Figures

Figure 1:	Key Steps for Implementation.....	24
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Appendices

Appendix A: Acronyms
Appendix B: Actuarial Analysis

1. INTRODUCTION

Public Consulting Group (PCG) was contracted to provide the Department of Health and Social Services (DHSS) with an initial roadmap for planning (hereinafter “Roadmap”) of an Alaska Health Insurance Exchange (hereinafter “Exchange”); examine health insurance exchange options; and provide recommendations regarding financial sustainability and exchange finance functions. This report provides the PCG methodology; results of the data gathering, PCG analysis, and recommendations for DHSS.

The Roadmap for planning provides DHSS with an implementation plan and a framework for Exchange strategic planning and design. Information is presented regarding goals and objectives and provides an examination of issues, as well as listing of data and analytical requirements for resolution. The implementation plan is presented for all different organizational Exchange options

The Exchange Design Options provide an examination of fiscal and operational issues that impact the planning and design of the Exchange, including governance, cost efficiency, staffing, and contracting needs to operate the Exchange under different potential models. The Exchange Design Options include the results of an actuarial analysis that assesses the State of Alaska’s public and private insurance marketplace and considers Alaskan demographics and its uninsured population. The challenges of integration of the Exchange into the current public and commercial Alaska insurance landscape was also reviewed and options for resolution presented.

The Communication Plan reviews different communication mechanisms for planning and design of the Exchange. The Communication Plan provides a discussion of potential stakeholders, presents effective methods for communication, and establishes the framework for a communication matrix. If the State of Alaska moves forward with the Exchange, the Communication Plan will provide the information needed to ensure stakeholders are engaged and will provide best practices for education of Alaska businesses, consumers, and government leadership.

As part of the analysis of whether to establish the Exchange, this report considers financial sustainability questions and conducts financial analysis of the different Exchange models. Financial sustainability examines the potential revenue streams that could support Exchange operations while containing costs to users of the system. Financial analysis reviews the establishment, operations, and maintenance costs associated with different Exchange models.

2. EXECUTIVE SUMMARY

The State of Alaska is examining the feasibility of a health insurance exchange. This report presents the results of the background research and presents: 1) a Roadmap for planning; 2) an overview of the Exchange design options; 3) a communication plan for conducting stakeholder outreach; 4) financial analysis of the different Exchange models; and 5) a discussion of the financial sustainability models currently being considered by states. This report also contains an actuarial analysis of the Alaska health insurance market.

2.1. Roadmap

The Roadmap was developed with the understanding of the national debate regarding the constitutionality of the federal healthcare reform legislation and the uncertainty surrounding the implementation. The State of Alaska's planning efforts to date have focused on gathering data that would assist with design, development, and implementation of an Exchange in the event the legislation is found constitutional and the State has to move forward. The initial planning goals for an exchange include the expansion of access to health insurance coverage and reduction of the uninsured rate. These high level goals will inform Exchange policy and operational decisions. The Roadmap provides a discussion of what key policy decisions need to be made and discusses the key decisions required for: 1) effective governance and administration; 2) eligibility determinations; 3) stakeholder engagement; 4) outreach, education, and enrollment; 5) the Web portal; 6) how to certify qualified health plans; 7) the essential health benefits determination; 8) customer service and consumer assistance requirements; and 9) financial sustainability. If the State of Alaska decides to establish an Exchange, the timeline for completion of the strategic planning efforts and implementation is extremely aggressive; thus, the Roadmap also provides an Implementation Plan and timeline. The Implementation Plan includes the timeline for a state-based Exchange as well as the federal partnership option and a federal exchange. A brief discussion is also included regarding the federal process for approval of exchanges.

2.2. Exchange Design Options

The Patient Protection and Affordable Care Act (ACA) provides that states may establish their health insurance exchanges as either a state-based exchange, a state-federal partnership exchange (with the state maintaining control over unique state functions that include plan management and consumer outreach and education), or a federally facilitated exchange. This report presents the overview of each of the different administrative models. Until recently, there was a presumption by the Centers for Medicare and Medicaid Services (CMS) and the states that if the ACA was found to be constitutional most states would establish their own state-based exchanges. However, with the level of uncertainty regarding the future of the legislation, and the aggressive timeframe for implementation, CMS and many states have changed direction and are seriously considering either the federal partnership models, or participation in a federally facilitated exchange with a transition to a state based exchange for 2016 and beyond. CMS is planning to be ready with the federally facilitated exchange and is now encouraging states that have not completed a significant amount of planning to consider starting their exchanges as either federally

facilitated or state federal partnerships. While this report provides a discussion of the different models and the advantages and disadvantages of each model, there is no specific recommendation regarding which model would make the most sense for the State of Alaska. If there was no political debate or controversy regarding health insurance exchanges, PCG would recommend the State consider initially implementing a state-federal partnership model with transition to a state-based exchange in 2016 or later. This recommendation would be based on objective factors that include planning time necessary to implement the information technology infrastructure necessary for a state-based exchange and the program integration with Medicaid and DenaliKids for eligibility and enrollment. The recommendation would be based on the fact that a state-federal partnership provides state autonomy regarding health plan management and consumer assistance and outreach. However, to date it is impossible to separate out the political impacts and clearly identify the actual cost of a state-federal partnership, so there remain too many unknowns for PCG to make a recommendation. PCG believes with the information provided in this report regarding the Exchange design models, and finality regarding the constitutionality of the ACA, the State of Alaska will be able to make an informed decision regarding the best model for the Exchange.

2.3. Communication Plan

If the State of Alaska moves forward with Exchange planning, one of the most important set of tasks that will ensure success of the Exchange is to forge the critical links among the stakeholders. The stakeholders include internal and external partners such as Medicaid, Denali KidCare, and tribal partners. Other community stakeholders include the insurance issuers and producers, small business owners, individual consumers, and non-profit consumer advocacy organizations such as the Alaskan Public Interest Research Group. The Communication Plan included in this report provides information regarding effective stakeholder identification, developing a two-way communication strategy and how to manage project communications to assure effective use of the information gathered.

2.4. Financial Sustainability

The Exchange has to be self-supporting by 2015; meaning that the total operating cost of the Exchange must be paid by revenues generated on behalf of the Exchange. These requirements apply regardless of whether the Exchange is a state-based exchange, a state-federal partnership, or federally facilitated exchange. This report provides an analysis of the different financial sustainability options. The analysis includes revenue options other than general funds, specifically: 1) qualified health plans (QHPs) administrative revenue; 2) consumer administrative fees; 3) accreditation fees to agents and brokers; 4) advertizing revenue; 5) commercial partnerships; 6) administrative fees to the reinsurance entity; 7) insurance plan market wide assessments; and 8) an industry wide assessment. The industry wide assessment would levy a fee on all health care industry members, including providers. The modeled cost of the Exchange is \$6,772,299.98. Based on the ability to raise this amount of revenue, the report recommends consideration of a consumer administrative fee (estimated to raise \$6,153,840.00 per year) supplemented with advertising revenue or other limited revenue stream.

2.5. Financial Analysis

The financial analysis in this report presents the assessment of the expected costs of operating the Exchange. These costs are estimated using the actuarial analysis with a prediction of Exchange enrollment of 77,000 (including the individual and SHOP). The core functions of the Exchange are incorporated in the cost, including staffing and capabilities that include premium billing functions and call center costs. PCG makes several important assumptions that may impact the cost estimate. Specifically, PCG assumes that any selected option will require State personnel time and modifications to existing systems; ranges are listed to account for variations in the solution design and scope – so the ultimate cost will vary depending on what is chosen as the actual scope of work. Finally, the estimates do not take into account the availability of federal matching funds in order to demonstrate the full costs of the system. Because of the unknowns regarding whether or not the State of Alaska will move forward with the Exchange and which model it may choose, it is premature to recommend one model over another.

2.6. Conclusion

In conclusion, this report provides the State of Alaska with deep background research and knowledge of the insurance market, as well as detailed information regarding the health insurance exchange options that are available to the State. When the uncertainty regarding the ACA is cleared up, this report will be a valuable resource for Alaska's next steps.

3. ROADMAP

Under the provisions of the ACA, supported by related federal guidance, a health insurance exchange will be operational in each state by January 1, 2014. Within this short timeframe, health insurance exchanges are expected to seamlessly integrate and coordinate a daunting number of moving parts. With the continuous release of new federal guidance and an ever-changing political horizon, getting lost in the details can feel almost inevitable. In order to maintain focus on Exchange objectives, Alaska must retain a “big picture” perspective on all planning and implementation activities. The Roadmap will support this perspective, ensuring that each analysis and decision promotes quality, cost efficiency, sustainability, and, most importantly, the ability to meet the needs of Alaskans by supporting the private sector insurance market and minimizing federal involvement in the State.

Given the litigation concerning the constitutionality of various provisions of the ACA, which Alaska is a party to, as well as the ongoing debate over federal health care reform and efforts to defund certain provisions of the law, PCG recognizes the need to develop a roadmap that provides the State with the nimbleness and flexibility to react to an evolving set of circumstances and changing policies, both internally and externally. This Implementation Plan included within the Roadmap outlines all options for the State should it choose to move forward with the Exchange.

3.1. Goals for the Alaska Exchange and Value Proposition

The following set of Exchange goals will inform all key policy and operational decisions to ensure that, should the State choose to move forward, the Exchange may effectively meet Alaska’s needs and expectations.

- Expand access to health insurance coverage and reduce the uninsured rate by at least five percent;
- Reduce uncompensated hospital care by at least five percent;
- Minimize federal involvement in Alaska’s health insurance market; and
- Streamline and minimize State government bureaucracy and administrative overhead.

For the potential insurance consumer, the Exchange intends to offer value by educating and familiarizing consumers with insurance products, increasing transparency in the marketplace, promoting competition, and increasing the overall purchasing power of individuals and small businesses.

For the insurance issuer, the Exchange will add value to their business by offering a new distribution channel for sales, promoting the benefits of insurance coverage and increasing the market base through outreach and enrollment activities, and supplying access to the exclusive subsidy-eligible market.

3.2. Key Policy Decisions

At its core, the Exchange is intended to attract and retain customers by offering comprehensive health plans at affordable prices. To accomplish this goal, the Exchange must: 1) establish a streamlined eligibility and enrollment process; 2) adjudicate transactions effectively and efficiently; and 3) provide members with information to make informed decisions. The following section provides information related to several key Exchange issues, outlining decision points that must be addressed and proposing additional analyses that may support decision making.

3.2.1. Governance and Administration

Issue Summary

One of the most immediate and important decisions for the State of Alaska is to determine the governance model and administrative structure for the Exchange. If the State chooses to establish an Exchange under State authority, the ACA allows for it to be organized in one of three ways:

1. Establish the Exchange within an existing State agency;
2. Create an independent State agency or quasi-State agency; or
3. Create a not-for-profit entity.

The State of Alaska may choose to establish and operate the Exchange by designating an existing State agency to run the Exchange. Under this approach, the agency would be responsible for implementing, overseeing, and managing the day-to-day operations of the Exchange. An advisory board may be established to provide input and offer advice on Exchange policies and procedures, but the ultimate decision-making authority would rest with the State agency. The Utah Exchange, which was established in 2008, is administered by the Governor's Office of Economic Development.

Alternatively, the State may choose to establish an independent State agency or quasi-State agency. In order to meet the United States Department of Health and Human Services (HHS) standards for establishment of the Exchange and prevent federal involvement in Exchange operations, this new entity must be governed by a board of directors under the guidance of a formal, publicly-adopted charter. The board of directors must include consumer representation and may not include a majority of members from the health insurance industry (e.g., issuers, agents, and brokers). The board of directors is also required to hold regular public meetings and establish conflict of interest standards and other transparency specifications. The Massachusetts Connector was established as a quasi-governmental authority and is overseen by an 11-member board of directors. California's Exchange is also a quasi-government authority under the direction of a five-member board.

As a third option, the State may designate a non-profit entity to run the Exchange. This option likely provides the greatest amount of separation from State government. The non-profit entity would be required to fulfill the same governance board requirements as the independent State or quasi-State agency described above. However, depending on Alaska's State laws and regulations regarding non-profits, such

an entity may be able to benefit from more flexible hiring and procurement requirements than those to which a State agency is subject. The Hawaii Health Connector has been established as a not-for-profit.

The State of Mississippi has chosen to establish its Exchange as a non-profit entity under the State's existing high risk pool. The legislation that originally established Mississippi's high risk pool granted fairly broad statutory authority that allows for the pool to both establish and administer an Exchange. Legal analysis of Alaska's high risk pool legislation would be required to determine the feasibility of exercising this option for the State.

Because the Exchange needs to coordinate with the activities of other State agencies, in particular with DOI and DHSS, the Exchange's governing board might include State officials with expertise in those areas. Such ex officio members could either be voting or non-voting members. The board might also include expertise from individuals with private health insurance experience, experience with the distribution of health insurance products, and a consumer representative.

If the State chooses not to establish a State-run Exchange, the State may choose to pursue a partnership with the federal government. Such a partnership may take one of three forms:

1. State Run Consumer Assistance
2. State Run Plan Management
3. State Run Consumer Assistance and Plan Management

These partnership options were intended to alleviate states' concerns regarding the feasibility of building and operating the extensive information technology (IT) systems required to support an Exchange under a short timeframe. Additional information on the details of these options is included in the Exchange Design Options report.

As a final option, the State of Alaska may also choose to establish a multi-state exchange in partnership with other states. While some low population states showed interest in this option, to date no state has declared that it will establish a multi-state exchange. Costs, time, and resources associated with establishing this type of exchange would entirely depend on the partner state that is chosen and that partner state's available resources.

Data and Analytical Requirements

The State of Alaska should consult with stakeholder groups regarding the Exchange governance model and potential for additional advisory boards. Preliminary discussions with members of the broker community have favored establishment of a non-profit State Exchange as the ideal choice. However, stakeholders understood that time requirements may make that choice more difficult. Stakeholders also expressed an interest in how the Alaska Comprehensive Health Insurance Association may be repurposed to support the Exchange. Carrier representation has stated that, given the short timeframe for IT development and implementation, the federal partnership option makes the most sense for Alaska in meeting the January 1, 2014 effective date for plan coverage as it will at least ensure that insurance business remains under the purview of the State.

Alaska should also consider the timelines that will be required for procurement and staffing if the State were to establish the Exchange and determine which model may best accommodate those timelines.

3.2.2. Eligibility Determination Process

Issue Summary

The ACA directs states to use a “single, streamlined form that: may be used [by individuals] to apply for all applicable State health subsidy programs within the State; may be filed online, in person, by mail, or by telephone; may be filed with an Exchange or with State officials operating one of the other applicable State health subsidy programs; and is structured to maximize an applicant’s ability to complete the form satisfactorily, taking into account the characteristics of individuals who qualify for applicable State health subsidy programs.”¹

In short, Alaska is expected to establish a single application and entry point, possibly feeding into a single eligibility engine, to determine eligibility for Medicaid, Denali KidCare, and the Exchange. The intent of this process is to enable an individual to supply a limited amount of information to determine whether the person is eligible for coverage under the various medical assistance programs available in the State.

The State of Alaska needs to start planning for the development of a system that can process applications and determine eligibility for all subsidized health insurance programs. In addition, a mechanism to capture and store eligibility and enrollment information for all publicly-subsidized health coverage programs will be needed to minimize the potential for individuals to be covered under more than one program simultaneously and to coordinate coverage across programs.

The eligibility process, whether via a single system or modular systems that are connected through an enterprise service bus, will determine whether an individual/family is eligible for coverage through Medicaid, Denali KidCare, or the Exchange, and whether the individual/family qualifies for premium subsidies and reduced cost sharing through the Exchange. Eligibility will be determined using four key pieces of information: 1) residency status (i.e., is the applicant a legal U.S. and Alaska resident); 2) availability of “affordable” and “qualified” employer-sponsored insurance (ESI)²; 3) family status and number of dependents; and 4) amount of modified adjusted gross income (MAGI) and percentage of the federal poverty level (FPL). In order to operate such a system, potential enrollees would need to provide the following information:

- Name, address, and date of birth for each member of the family;

¹ Section 1413 of the ACA.

² For the purpose of determining eligibility for subsidized coverage through the Exchange, ESI will be considered “affordable” if the employee’s share of the premium is no more than 9.5% of the applicant’s modified adjusted gross income, and the insurance has an actuarial value of at least 60% (i.e., the health plan’s premiums cover 60% of the cost of care for the average enrollee).

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- Social security number and/or immigration status;
 - Income information and family size; and
 - Availability of employer-sponsored insurance, including:
 - Whether the applicant is a fulltime employee, and if so:
 - Whether the applicant was offered coverage by their employer,
 - The lowest cost health plan offered by the employer and the employee's share of the premium for single coverage, and
 - The name, address, and employer identification number (if available) of the employer.

This information, and potentially other data, needs to be captured to determine an applicant's eligibility for various health coverage programs. Eligible members would then be transferred to the appropriate health coverage program (e.g., Medicaid, Denali KidCare, Exchange), at which point the applicant will continue with the enrollment process.

Data and Analytical Requirements

Within the Exchange Design Options report, high level budget estimates were projected for an integrated eligibility system using currently available information and information gathered from other states. To assess the feasibility of the State's current eligibility process being modified to meet the needs of an expanded Medicaid program, Denali KidCare, and the Exchange in time to commence open Exchange enrollment on October 1, 2013 and meet the January 1, 2014 effective date of coverage, the following analyses should occur:

- Develop a comprehensive overview of current infrastructure, applications, interfaces, and business processes that are presently used to determine eligibility for publicly-subsidized health coverage programs;
- Modify budget estimates for the design, development, and implementation of a modified eligibility engine, if necessary and appropriate; and
- Modify timeline for completing the eligibility engine project to meet the January 1, 2014 effective date of coverage.

In developing a plan for a single, streamlined eligibility process for all medical assistance programs, the State may also consider incorporating, over time, the eligibility processes and requirements for non-medical assistance programs available to lower-income residents; including Temporary Assistance for Needy Families (TANF), the Supplemental Nutrition Assistance Program (SNAP), and child support.

3.2.3. Stakeholder Engagement

Issue Summary

One of the first critical steps in development and implementation of the Exchange is the upfront identification of all vested State staff and departments, external stakeholders, and decision makers. Consultation with the following stakeholder groups is statutorily required of the Exchange:

- Health care consumers who would potentially enroll in a QHP, including consumers with disabilities;
- Individuals and entities with experience in facilitating enrollment in health coverage;
- Advocates for hard-to-reach populations, including those with disabilities, mental health disorders, substance use disorders, and those facing cultural and/or linguistic barriers to enrollment;
- Small businesses and self employed individuals;
- State Medicaid and Denali KidCare agencies and beneficiaries;
- American Indians and Alaskan Natives;
- Public health experts;
- Health care providers;
- Large employers;
- Health insurance issuers; and
- Agents and brokers.

The State has flexibility in how it may structure interaction with stakeholders on an ongoing basis. Some states have chosen to establish formal work groups consisting of membership representing all of the above categories. For these states, ensuring that chosen representatives do in fact represent the broader consensus of their groups and effectively coordinating regular and productive meetings for each work group has been a top priority.

Other states have chosen to take a broader approach to stakeholder consultation, engaging the general public on a regular basis and organizing focus groups with varied participation to ensure a fuller range of participation in the process. For this type of process, ongoing public education is critical to ensuring that any feedback received is based on a solid understanding of the requirements facing the State and the implications of major policy decisions.

Data and Analytical Requirements

The State of Alaska should undertake a stakeholder analysis to identify contacts within the State that may represent each of the broad categories described above.

Once a communication and meeting schedule has been established and executed, the State should conduct a thorough analysis of stakeholder input to ensure appropriate inclusion in specific Exchange analytic and

design activities. A proposed approach for continued stakeholder engagement and analysis is included within the Communications Plan.

3.2.4. Outreach, Education and Enrollment

Issue Summary

If the Exchange is to attract the necessary volume of individuals, families, and small businesses to support its operations, it needs to develop a multi-pronged outreach, education, and enrollment program. Such an effort might include a wide array of organizations and individuals, including the Exchange, Medicaid, Denali KidCare, other social service agencies, brokers, schools, community based organizations, faith based organizations, business groups and associations, hospitals, community health centers, physicians, health insurers, paid media, and public service announcements. These efforts must convey two essential and sequential messages:

1. Health coverage is important.
2. The Exchange can help you find the right coverage for you.

As part of their outreach and education strategy for state-run exchanges, most states are planning to engage in some level of traditional media advertising, which may include television and radio spots, print press releases, and Web advertising. This type of marketing is intended to increase general awareness about health coverage issues and exchanges, creating a recognizable name and “face” for the entity. Recognition of the Exchange as a legitimate organization will also assist on-the-ground outreach workers in encouraging individuals to use the Exchange.

In-person, targeted outreach represents the largest and most important form of outreach and education for the Exchange. Navigator organizations will likely comprise the main outreach arm of this effort. Effective Navigators are individuals or organizations who are trusted members of the communities they serve that provide culturally and linguistically appropriate information to their communities. Navigators may include trade, industry, and professional associations, commercial fishing industry organizations, ranching and farming organizations, community and consumer-focused nonprofit groups, chambers of commerce, unions, resource partners of the Small Business Administration, insurance agents and brokers. The final rule released by HHS this spring requires that an exchange include at least one community or consumer-focused non-profit group as a Navigator entity.

While Navigators and insurance brokers serve similar roles, the role of the Navigator must stop short of attempting to provide information regarding specific insurance products. Navigator management must include appropriate training, monitoring, and corrective action planning to ensure that Navigators do not cross the fine line between conducting general outreach and transacting insurance. Some states are planning to regulate Navigator functionality through the same entity that regulates commercial insurance in order to manage this division of duties.

Navigators are funded through grants provided by the Exchange as part of the Exchange’s ongoing operating expense. Some states are planning to establish grants as block grant funding, while others are

planning to establish an enrollment based funding mechanism. In an effort to promote impartiality, Navigator organizations are prohibited from receiving compensation from insurance carriers to enroll individuals in Exchange plans.

Both Navigators and insurance brokers will require a new level of training in order to effectively assist consumers in the Exchange. Training should include basics regarding Exchange operations, contacts, and assistance programs to allow Navigators and brokers to successfully guide consumers through the Website and use the Website themselves. A substantial portion of training will include information on eligibility for new public assistance programs.

Data and Analytical Requirements

A key source of information in designing an effective outreach program will be the best practices and lessons learned from past outreach programs in the State of Alaska. A critical first step in this process will be analysis and identification of activities, organizations, and established communication networks that may be leveraged to support Exchange outreach. Preliminary meetings with Alaskan stakeholders suggested that the State look to programs conducted by Denali KidCare, Yukon-Kuskokwim Health Corporation, and Bristol Bay Health Corporation for best practices in outreach to the individual consumer, American Indians, and Alaskan Natives.

Stakeholders from Alaska's tribal organizations highlighted the fact that outreach workers engaging a number of villages in remote areas will require air travel to reach those populations. The State will also need to carefully plan the Navigator program and outreach activities in order to account for the vast number of languages spoken throughout the State. These two factors that are unique to Alaska will increase the expense associated with outreach efforts several fold.

Focused stakeholder consultation will be especially critical to designing an effective outreach campaign. It is important to consider that, while the challenges impacting Exchange outreach in Alaska are substantial, Alaskans know their communities better than anyone else and have implemented successful outreach campaigns in the past. Effectively leveraging and combining this knowledge of individual market segments will be key to successful Exchange implementation.

3.2.5. Web Portal

Issue Summary

The Web portal will serve as a central point of access for individuals and employers to obtain general information, compare health plans, enroll in coverage, and update their account throughout the year.

The Web portal needs to include, at a minimum, the following functionality:

- A seamless link to the State's eligibility engine to allow individuals and families to determine if they are eligible for all health coverage programs. Individuals determined eligible for Medicaid or Denali KidCare will be pointed to those programs to complete the enrollment process; while individuals eligible for coverage through the Exchange (whether or not they are eligible for premium subsidies and reduced cost sharing) will

continue on the Exchange Website to evaluate their health plan options and continue with the enrollment process.

- For legal residents who are not offered employer sponsored insurance, with income between 138 percent and 400 percent effective FPL, the platform supporting the Web portal must be able to receive data from the eligibility engine in order to calculate the premium subsidies and reduced cost sharing for which an individual or family may be eligible. The Web portal must be able to generate and display rates (or obtain rates from the issuers in “real time”) for all health plans, apply the appropriate premium subsidy and cost sharing reduction, and display that information for the eligible individual/family.
- The Web portal needs to include a cost calculator that provides an estimate of the total cost of coverage, including premiums and potential out-of-pocket exposure associated with point-of-service cost-sharing. The cost calculator could be set up to allow an individual to enter member-specific information on expected health care utilization (e.g., office visits, prescription drugs, outpatient care, inpatient admissions, etc.), which could then be used to generate potential member costs for the various health plans offered through the Exchange. This will require linking benefit designs (i.e., deductibles, co-pays, and coinsurance) for health plans offered through the Exchange to a tool that is capable of generating member-specific cost estimates. Such functionality has been developed in the private market and is currently utilized in both public and private exchanges already in operation.

The Website also needs to display benefit summaries to allow a customer to compare health plans. This will likely include both a summary plan description that captures the major benefits and applicable cost sharing, as well as a link to more detailed benefits information. The HHS Website www.healthcare.gov provides a template and samples of benefit summaries.

Search functionality on the Website must also include an optional provider search tool to enable an individual to enter his or her doctor’s name or a hospital’s name to determine which of the Exchange’s health plans include the doctor or hospital in their respective provider network.

The Website needs to display comparative information on the quality and customer satisfaction associated with health carriers and health plans offered through the Exchange. The specific types of information to be made public will be developed by HHS, but will include claims payment policies and practices, financial disclosures, enrollment and disenrollment information, claims denied, rating practices, out-of-network coverage and cost sharing, and enrollee rights.

Data and Analytical Requirements

The State should review information available from other states, including information posted to CALT to identify public and private resources that may be leveraged to support this functionality. A review of existing private sector systems that currently operate in the marketplace would allow the State to better understand the types of systems available, the strengths and weaknesses of these systems, and the potential to leverage existing technologies.

The State should consider whether it will be necessary to issue a new Request for Information (RFI) for the various component pieces associated with a fully-functioning Exchange, including a premium

generator/rating engine, premium aggregator, health benefits display and comparison, consumer decision-support tools, enrollment brokerage system, and cost calculator. A number of states have previously issued RFIs for these functions, which are available on CALT. However, the State may find that special considerations with respect to Alaska's population and market may affect the applicability of these resources.

3.2.6. Essential Health Benefits Determination

Issue Summary

The ACA requires that any health insurance plan that is offered to an individual or small business must cover the ten broad categories of services that are listed below. This list represents the minimum services that must be covered. Plans may cover additional services at their own discretion.

1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and substance use disorder services, including behavioral health treatment;
6. Prescription drugs;
7. Rehabilitative and habilitative services and devices;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care.

The ACA requires HHS to provide more details on the above categories in order to create a comprehensive essential health benefits (EHB) package. According to the ACA, the EHB package is intended to represent "the scope of benefits provided under a typical employer plan." After receiving input from the Department of Labor, the Institute of Medicine, and other stakeholders, HHS released a "benchmark" approach for defining the EHB package.

Under this approach, rather than defining one EHB package that would apply to all states, each state may choose its own benchmark plan to act as the EHB for that state. In a December 2011 Bulletin, HHS provided four benchmark options from which the State may choose.

1. One of the three largest small group plans in the State by enrollment;
2. One of the three largest State employee health plans by enrollment;

-
3. One of the three largest federal employee health benefit plan (FEHBP) options by enrollment; or
 4. The largest HMO plan offered in the State's commercial market by enrollment.

Once the State has chosen a benchmark plan, all other plans in the individual and small group markets will be required to offer benefits that are "substantially equal" to the benchmark. Plans will have the flexibility to adjust the specific services that are included as part of the benefit, as well as any quantitative limits on certain services, as long as the coverage has the same *value* as the benchmark.

The ACA requires the State to pay for the portion of Exchange premiums that are attributable to State insurance mandates not included in the EHB package. This provision was intended to ensure that federal dollars would not be used to subsidize coverage of State mandates in the Exchange. However, by choosing a plan that is currently offered in the State, and therefore includes all current insurance mandates, the State essentially guarantees that no insurance mandates fall outside of the EHB package. HHS added that while a state plan will likely remain a benchmark option through 2015, future updates to the benchmark may eliminate that possibility. Thus states are encouraged to continually monitor the necessity and effectiveness of their current state mandates.

HHS expects to formally propose that EHB benchmark options will be updated in the future to ensure that benefits reflect the most current and appropriate medical practices and insurance market practices. The schedule and scope of those updates has yet to be released, but will require carefully balancing the desire for innovation with the need for stability and reliability.

Data and Analytical Requirements

Determining the most appropriate EHB benchmark plan for the State of Alaska requires two broad analyses: 1) a comparison of the coverage provided by plan options; and 2) an analysis of the cost impact on premiums for each option.

Coverage analysis begins by laying out all benchmark options available in the State of Alaska by service category. This comparison is intended to illustrate the robustness of coverage, identify limitations, and ensure that the ten broad EHB categories are substantially covered by each option. Once this basic exercise is complete, stakeholder input should be considered to ensure that the benchmark does not eliminate or materially limit coverage that is considered essential to Alaskans.

An actuarial analysis of the plan options will then determine whether and to what extent each plan option would impact premium levels in the State. This analysis should be used to weight each of the plan options, ensuring that the final benchmark choice provides an optimal balance of cost and coverage.

3.2.7. Health Plan Selection and Management

Issue Summary

The ACA outlined a set of core requirements that each QHP must meet in order to be offered on the Exchange. Broadly, these requirements focus on improving the quality of coverage for the consumer and

include the essential health benefits standards described previously and minimum actuarial value³ (AV) standards outlined below:

- Platinum: 90% AV
- Gold: 80 % AV
- Silver: 70% AV
- Bronze: 60% AV

To ensure that these and other standards related to ongoing plan management and quality assurance are met, the Exchange must establish processes for conducting the following functions:

1. Establish health plan selection criteria, consistent with requirements issued by the federal government, and certify QHPs from health carriers to be offered through the Exchange;
2. Implement procedures for certification, recertification, and decertification of QHPs;
3. Evaluate premium levels and cost sharing requirements in determining whether to allow a health plan to be offered through the Exchange;
4. Require plans to meet marketing standards and not use marketing practices or benefit designs that discourage enrollment of high-risk individuals and groups;
5. Ensure that health plans offer sufficient choice of providers;
6. Require that health plans include essential community providers, where available, that serve predominately low-income, medically underserved populations;
7. Rate each health plan offered through the Exchange based on price and quality criteria;
8. Require plans to implement a quality improvement strategy designed to improve health outcomes;
9. For all eligible applicants, make available four levels of “qualified health plans” – Platinum, Gold, Silver, and Bronze – based on their AVs, which range from 90 percent (Platinum) to 60 percent (Bronze);
10. For individuals under 30 years of age and for people determined exempt from the individual mandate, make available a “catastrophic,” or high deductible health plan; and
11. Allow an issuer of a stand-alone dental plan, which may be sold separately or in conjunction with a QHP, to offer the product through the Exchange.

³ Actuarial value is defined as the proportion of total medical expenses that an insurance plan premium is expected to cover.

To avoid duplication of effort, many states are considering housing plan management functionality under the current insurance regulatory entity. Staffing will likely be augmented to handle those functions that are not currently performed in the State. Some states are also considering ways to streamline their rate filing systems and other operational activities across the entire insurance market to maximize efficiency of Exchange plan management incorporation.

Data and Analytical Requirements

If the State considers housing these functions within DOI, an operational analysis should be conducted to determine whether and how many additional staff members will be required to fulfill Exchange functional requirements, as well as which system modifications or other operational upgrades will be required to manage Exchange plans. If housing Exchange plan management functionality within DOI is considered infeasible, the State needs to identify how coordination between DOI and the Exchange will be achieved in order to ensure seamless application of plan management standards and avoid risk selection issues inside and outside of the Exchange.

3.2.8. Customer Service and Consumer Assistance

Issue Summary

The need for consumer assistance reflects the fact that most Alaskans (and most U.S. residents, in general) have never purchased health insurance on their own. Most individuals obtain insurance through their employer (perhaps choosing from among a very limited number of plans), receive publicly subsidized coverage from Medicaid or Medicare, or remain uninsured.

The Exchange team needs to develop a robust consumer assistance and customer support team that will be able to help individuals understand the complex terminology associated with health insurance, help people file grievances and appeals, provide information on consumer protection provisions, and collect information on inquiries and problems and how they were resolved.

In setting up the customer service program, the Exchange needs to consider the current services being provided by consumer assistance entities, and seek to leverage any existing resources that may be available. In addition, the Exchange needs to work with Medicaid, Denali KidCare, tribal health organizations, and other social service programs that have established some form of customer service program designed to assist people in completing applications for public assistance programs and provide information to existing and potential beneficiaries.

With respect to the call center, the State needs to consider the role of Navigators, brokers, and health insurers, among others, to determine the types of questions the call center will handle, the services that need to be provided, and how best to distribute the workload among these parties. Some states are establishing the call center as essentially an operator system, staffed by individuals who are trained to triage consumer calls based on their questions and needs and connect them with the most appropriate resource. For the State of Alaska, this type of call center may be especially efficient considering the vast number of languages spoken throughout the State. Other states have chosen to staff their call centers

exclusively with individuals who are licensed to transact insurance. These states are aiming to minimize the number of contacts an individual would need to access in order to find the answers they need.

In most states, it is expected that brokers will play a key role in consumer assistance for the Exchange. Under current conditions, brokers who enroll an individual in a plan receive compensation for that enrollment and continue to support that individual when they have questions or concerns regarding their insurance coverage. In keeping with ACA limitations and current Alaskan insurance regulations, the State may want to consider alternative forms of compensation for insurance brokers so that they may be leveraged to provide consumer assistance for individuals who chose to enroll in coverage without using a broker.

Data and Analytical Requirements

Similar to outreach, education, and enrollment planning, the State may benefit substantially from stakeholder consultation in this area. Identifying and coordinating existing resources that may be leveraged to support this functionality will minimize both the cost and time required to implement a successful customer service network.

3.2.9. Financial Sustainability

Issue Summary

For most states, this issue area is the most important and most contentious part of Exchange planning. Like any new business, the Exchange must consider how much its services are worth on the open market, what fraction of the market it expects to capture, and how expected revenue will cover expected costs. A financial sustainability plan may be broken down into five main steps:

1. Market Projections: In order to fully analyze all options available for financial sustainability, the State must first understand how many individuals are expected to enroll in the market, both through individual coverage and small group coverage. This enrollment number provides a baseline for projecting variable costs and initial capacity requirements for various Exchange functions.
2. Budget: Budget projections begin with construction of an Exchange organizational structure. Any new staff positions or shared positions with other agencies are included by fulltime equivalency (FTE). For states that have chosen to establish an independent State agency or to operate the Exchange as part of an existing State agency, government salary benchmarks and fringe rates apply. For states looking to establish a nonprofit entity, market-competitive salaries should be used.

For the purposes of an initial budget, the most straight forward approach to capturing costs is to group expenses into large functional categories. Under this model, the budget may be used to reflect the total available budget for competitive procurement, for additional internal staffing, or to expand capacity of existing systems and offices to include Exchange functionality. Thus a complete draft budget may be developed prior to finalizing build-or-buy decisions.

Benchmarking using budget projections developed by other state Exchanges, private Exchanges, and current State business processes is the most common and likely most appropriate approach to budget development.

3. Expected Revenue: Once a high level understanding of expected costs has been defined, all feasible revenue sources should be considered to cover Exchange operating costs. Some states are attempting to rely heavily on advertising, Medicaid cost allocation, and other non-consumer directed revenue sources. Other states have decided to apply a simple user fee on Exchange plans, while still others are considering some form of statewide assessment to cover costs.
4. Pro Forma Balance Sheet and Income Statement: The pro forma balance sheet and income statement will combine budget and revenue projections to form the foundation of the Exchange's accounting system.
5. Contingency Planning: Given the inherent uncertainty of market projections for any new product, the Exchange should consider implementing a mix of potential revenue streams to ensure that fixed costs are met regardless of enrollment. For some states, this process will involve a careful cost allocation plan to ensure that Medicaid matching funds are appropriately captured combined with, potentially, reinsurance transaction fees, advertising revenue, etc. For other states, the contingency plan will default to the use of general funds while the Exchange is reorganized to address funding shortfalls.

Data and Analytical Requirements

The financial model and actuarial analysis provided in the Exchange Design Options section herein provides a strong basis for this analysis, including enrollment projections, budget projections, and an analysis of revenue options to support ongoing operations. Once other key decision have been made with respect to leveraged resources and build-or-buy options, the State should revisit the financial model to fine tune expected costs and cash flows for operations.

3.3. Implementation Plan and Timeline

The overarching implementation plan for the Exchange will take a very different form depending on the governance and administration structures that are chosen. In order to prepare the State of Alaska to make the best decision going forward, the following section provides an overview of implementation steps and time requirements for each form of governance and administration structure.

Prior to making a final governance and administration decision, there are four key steps that the State may take in preparation for the Exchange. The results of this report and the Exchange Design Options analysis will substantially complete the first three of those steps.

Figure 1: Key Steps for Implementation



3.3.1. State Exchange

The following table describes an implementation plan for a fully State-operated Exchange under each of the three governance options.

Table 1: Implementation Plans for Governance Options

Full State					
Date	Non Profit	Date	Independent State Agency	Date	Existing State
Jul 2012	Project Schedule and Budget: Develop detailed project schedule, including key dates and milestones for Exchange implementation and projection of start up costs for each step.	Jul 2012	Project Schedule and Budget: Develop detailed project schedule, including key dates and milestones for Exchange implementation and projection of start up costs for each step.	Jul 2012	Project Schedule and Budget: Develop detailed project schedule, including key dates and milestones for Exchange implementation and projection of start up costs for each step.

Jul 2012	Develop requirements for governance board and interim decision making authority. Draft policies and procedures related to conflict of interest, program integrity, procurement SOPs. Determine if additional advisory boards will be established and the membership of those boards.	Jul 2012	Develop requirements for governance board and interim decision making authority. Draft policies and procedures related to conflict of interest, program integrity, procurement SOPs. Determine if additional advisory boards will be established and the membership of those boards.	Jul 2012	Determine which existing state agency will house the Exchange and identify administrative structure. Determine if additional advisory boards will be established and the membership of those boards.
Aug 2012	<p>Resource Utilization Plan: For all other Exchange functions, determine whether State resources may be able to integrate functionality or if additional staffing could best support the Exchange. All of the following are addressed in this plan:</p> <ul style="list-style-type: none"> ▪ Qualified Health Plan (QHP) certification ▪ Oversight and financial integrity ▪ Quality monitoring and improvement (e.g. customer satisfaction surveys, ratings, information disclosure, data reporting) ▪ Call Center ▪ Navigator Program ▪ Website, including applicable calculators ▪ Outreach and Education ▪ Individual eligibility determinations and appeals ▪ Facilitation of enrollment in QHPs, including special enrollment periods ▪ Small business eligibility determination ▪ Facilitation of 	Aug 2012	<p>Resource Utilization Plan: For all other Exchange functions, determine whether State resources may be able to integrate functionality or if additional staffing could best support the Exchange. All of the following are addressed in this plan:</p> <ul style="list-style-type: none"> ▪ Qualified Health Plan (QHP) certification ▪ Oversight and financial integrity ▪ Quality monitoring and improvement (e.g. customer satisfaction surveys, ratings, information disclosure, data reporting) ▪ Call Center ▪ Navigator Program ▪ Website, including applicable calculators ▪ Outreach and Education ▪ Individual eligibility determinations and appeals ▪ Facilitation of enrollment in QHPs, including special enrollment periods ▪ Small business eligibility determination ▪ Facilitation of enrollment, including special enrollment periods 	Aug 2012	<p>Resource Utilization Plan: For all other Exchange functions, determine whether State resources may be able to integrate functionality or if additional staffing could best support the Exchange. All of the following are addressed in this plan:</p> <ul style="list-style-type: none"> ▪ Qualified Health Plan (QHP) certification ▪ Oversight and financial integrity ▪ Quality monitoring and improvement (e.g. customer satisfaction surveys, ratings, information disclosure, data reporting) ▪ Call Center ▪ Navigator Program ▪ Website, including applicable calculators ▪ Outreach and Education ▪ Individual eligibility determinations and appeals ▪ Facilitation of enrollment in QHPs, including special enrollment periods ▪ Small business eligibility determination ▪ Facilitation of enrollment, including special enrollment periods ▪ Premium aggregation for qualified employers

	<p>enrollment, including special enrollment periods</p> <ul style="list-style-type: none"> ▪ Premium aggregation for qualified employers 		<ul style="list-style-type: none"> ▪ Premium aggregation for qualified employers 		
Jul - Aug 2012	<p>Eligibility System Determination: Final decisions made with respect to eligibility system upgrades and the feasibility of completing integrated system prior to Exchange launch. Contingency plan made to demonstrate significant progress in meeting eligibility system requirements. Resources involved include Medicaid, DOI, Denali KidCare, and other social service programs.</p>	Jul - Aug 2012	<p>Eligibility System Determination: Final decisions made with respect to eligibility system upgrades and the feasibility of completing integrated system prior to Exchange launch. Contingency plan made to demonstrate significant progress in meeting eligibility system requirements. Resources involved include Medicaid, DOI, Denali KidCare, and other social service programs.</p>	Jul - Aug 2012	<p>Eligibility System Determination: Final decisions made with respect to eligibility system upgrades and the feasibility of completing integrated system prior to Exchange launch. Contingency plan made to demonstrate significant progress in meeting eligibility system requirements. Resources involved include Medicaid, DOI, Denali KidCare, and other social service programs.</p>
Aug 2012	<p>Draft QHP requirements and quality monitoring processes</p>	Aug 2012	<p>Draft QHP requirements and quality monitoring processes</p>	Aug 2012	<p>Draft QHP requirements and quality monitoring processes</p>
Sep 2012	<p>Procurement Plan: For each function that may not be supported by current or expanded State resources, the procurement plan will identify RFI and RFP requirements, bid evaluation needs and timing, contract approval processes, project completion requirements, and an overarching quality assurance process</p>	Sep 2012	<p>Procurement Plan: For each function that may not be supported by current or expanded State resources, the procurement plan will identify RFI and RFP requirements, bid evaluation needs and timing, contract approval processes, project completion requirements, and an overarching quality assurance process</p>	Sep 2012	<p>Procurement Plan: For each function that may not be supported by current or expanded State resources, the procurement plan will identify RFI and RFP requirements, bid evaluation needs and timing, contract approval processes, project completion requirements, and an overarching quality assurance process</p>
Sep 2012	<p>Operational Readiness: For those resources identified in resource utilization plan, determine how many additional staff members are required to fulfill Exchange functions. Analyze how process flows will work to incorporate Exchange plan management and oversight.</p>	Sep 2012	<p>Operational Readiness: For those resources identified in resource utilization plan, determine how many additional staff members are required to fulfill Exchange functions. Analyze how process flows will work to incorporate Exchange plan management and oversight.</p>	Sep 2012	<p>Operational Readiness: For those resources identified in resource utilization plan, determine how many additional staff members are required to fulfill Exchange functions. Analyze how process flows will work to incorporate Exchange plan management and oversight.</p>

Sep 2012	Revise Financial Sustainability Plan to reflect resource utilization, procurement strategy, and staffing needs	Sep 2012	Revise Financial Sustainability Plan to reflect resource utilization, procurement strategy, and staffing needs	Sep 2012	Revise Financial Sustainability Plan to reflect resource utilization, procurement strategy, and staffing needs
Sep – Oct 2012	Develop and release RFPs as applicable according to procurement plan	Sep – Oct 2012	Develop and release RFPs as applicable according to procurement plan	Sep – Oct 2012	Develop and release RFPs as applicable according to procurement plan
Sep – Dec 2012	Hire and train staff as applicable	Sep – Dec 2012	Hire and train staff as applicable	Sep – Dec 2012	Hire and train staff as applicable
Dec 2012	Draft Navigator requirements, monitoring, oversight, and quality assurance processes	Dec 2012	Draft Navigator requirements, monitoring, oversight, and quality assurance processes	Dec 2012	Draft Navigator requirements, monitoring, oversight, and quality assurance processes
Dec 2012	Release RFP for marketing services	Dec 2012	Release RFP for marketing services	Dec 2012	Release RFP for marketing services
Feb – Apr 2013	Train Navigators on Exchange functionality, roles, responsibilities, and limitations	Feb – Apr 2013	Train Navigators on Exchange functionality, roles, responsibilities, and limitations	Feb – Apr 2013	Train Navigators on Exchange functionality, roles, responsibilities, and limitations
Mar 2013	Begin QHP application process	Mar 2013	Begin QHP application process	Mar 2013	Begin QHP application process
Apr 2013	Begin outreach campaign 6 months prior to open enrollment	Apr 2013	Begin outreach campaign 6 months prior to open enrollment	Apr 2013	Begin outreach campaign 6 months prior to open enrollment
May 2013	Certify qualified QHPs	May 2013	Certify qualified QHPs	May 2013	Certify qualified QHPs
May 2013	Beta testing for Alaska Exchange functionality	May 2013	Beta testing for Alaska Exchange functionality	May 2013	Beta testing for Alaska Exchange functionality
May – Jun 2013	Train brokers on Exchange functionality, roles, and limitations	May – Jun 2013	Train brokers on Exchange functionality, roles, and limitations	May – Jun 2013	Train brokers on Exchange functionality, roles, and limitations
Oct 2013	Commence open enrollment	Oct 2013	Commence open enrollment	Oct 2013	Commence open enrollment

3.3.2. Federal Partnership Options

The following table includes implementation plans for each of the Exchange partnership options:

- State-operated Plan Management: PM
- State-operated Consumer Assistance: CA
- State-operated Plan Management and Consumer Assistance: PM/CA

Table 2: Implementation Plans for Federal Partnership Options

Date	PM Partnership	Date	CA Partnership	Date	PM/CA Partnership
July 2012	Project Schedule and Budget: Develop detailed project schedule, including key dates and milestones for Exchange implementation and projection of start up costs for each step.	July 2012	Project Schedule and Budget: Develop detailed project schedule, including key dates and milestones for Exchange implementation and projection of start up costs for each step.	July 2012	Project Schedule and Budget: Develop detailed project schedule, including key dates and milestones for Exchange implementation and projection of start up costs for each step.
Aug 2012	Resource Utilization Plan: Identify which State entity will house plan management functionality and who will oversee operations. Determine additional functionality that must be incorporated into State entity operations.	Aug 2012	Resource Utilization Plan: Identify which State entity will house consumer assistance functionality and who will oversee operations. Determine additional functionality that must be incorporated into State entity operations.	Aug 2012	Resource Utilization Plan: Identify which State entity will house plan management and consumer assistance functionality and who will oversee operations. Determine additional functionality that must be incorporated into State entity operations.
Aug 2012	Draft QHP requirements and quality monitoring processes			Aug 2012	Draft QHP requirements and quality monitoring processes
		Sep 2012	Procurement Plan: For each function that may not be supported by current or expanded State resources, the procurement plan will identify RFP requirements, bid evaluation needs and timing, contract approval processes, project completion requirements, and an overarching quality assurance process	Sep 2012	Procurement Plan: For each function that may not be supported by current or expanded State resources, the procurement plan will identify RFP requirements, bid evaluation needs and timing, contract approval processes, project completion requirements, and an overarching quality assurance process
Sep 2012	Operational Readiness: For those resources identified in resource utilization plan, determine how many additional staff members are required to fulfill Exchange functions. Analyze how process flows will work to incorporate Exchange plan management and oversight.	Sep 2012	Operational Readiness: For those resources identified in resource utilization plan, determine how many additional staff members are required to fulfill Exchange functions. Analyze how process flows will work to incorporate Exchange plan management and oversight.	Sep 2012	Operational Readiness: For those resources identified in resource utilization plan, determine how many additional staff members are required to fulfill Exchange functions. Analyze how process flows will work to incorporate Exchange plan management and oversight.
Sep 2012	Revise financial sustainability plan to reflect resource utilization and staffing needs	Sep 2012	Revise financial sustainability plan to reflect resource utilization and staffing needs	Sep 2012	Revise financial sustainability plan to reflect resource utilization and staffing needs

Oct 2012	Communicate operational costs to CCIIO and develop plan for shared FFE revenue to support costs	Oct 2012	Communicate operational costs to CCIIO and develop plan for shared FFE revenue to support costs	Oct 2012	Communicate operational costs to CCIIO and develop plan for shared FFE revenue to support costs
		Sep – Oct 2012	Develop RFPs as applicable according to procurement plan	Sep – Oct 2012	Develop RFPs as applicable according to procurement plan
Oct 2012	Analyze additional integration points with FFE and develop integration plan for Medicaid and Denali KidCare eligibility support	Oct 2012	Analyze additional integration points with FFE, develop risk mitigation strategy for non-Exchange market, and draft integration plan for Medicaid and Denali KidCare eligibility support	Oct 2012	Analyze additional integration points with FFE and draft integration plan for Medicaid and Denali KidCare eligibility support
Nov 2012	Draft communications and data sharing protocols as applicable	Nov 2012	Draft communications and data sharing protocols as applicable	Nov 2012	Draft communications and data sharing protocols as applicable
Sep – Nov 2012	Hire and train staff as applicable	Sep – Nov 2012	Hire and train staff as applicable	Sep – Nov 2012	Hire and train staff as applicable
		Dec 2012	Draft Navigator requirements, monitoring, oversight, and quality assurance processes	Dec 2012	Draft Navigator requirements, monitoring, oversight, and quality assurance processes
		Dec 2012	Release RFP for marketing services	Dec 2012	Release RFP for marketing services
		Feb – Apr 2013	Train Navigators on Exchange functionality, roles, responsibilities, and limitations	Feb – Apr 2013	Train Navigators on Exchange functionality, roles, responsibilities, and limitations
Mar 2013	Begin QHP application process			Mar 2013	Begin QHP application process
		Apr 2013	Begin outreach campaign 6 months prior to open enrollment	Apr 2013	Begin outreach campaign 6 months prior to open enrollment
May 2013	Certify qualified QHPs			May 2013	Certify qualified QHPs
		May – Jun 2013	Train brokers on Exchange functionality, roles, and limitations	May – Jun 2013	Train brokers on Exchange functionality, roles, and limitations
Oct 2013	Commence open enrollment	Oct 2013	Commence open enrollment	Oct 2013	Commence open enrollment

3.3.3. Limited Time Partnership

The following section describes the implementation timeline required if the State were to start with a federal partnership option and transition from a full federally facilitated infrastructure for the remaining Exchange functions to a fully State-operated Exchange.

Table 3: Implementation Plan for Limited Time Partnership Option

Date	Limited Time Partnership
Jul 2012	Project Schedule and Budget: Develop detailed project schedule, including key dates and milestones for Exchange implementation and projection of start up costs for each step.
Aug - Sep 2012	Resource Utilization Plan: For all other Exchange functions, determine whether State resources may be able to integrate functionality or if additional staffing could best support the Exchange. All of the following are addressed in this plan: <ul style="list-style-type: none"> ▪ Qualified Health Plan (QHP) certification ▪ Oversight and financial integrity ▪ Quality monitoring and improvement (e.g. customer satisfaction surveys, ratings, information disclosure, data reporting) ▪ Call Center ▪ Navigator Program ▪ Website, including applicable calculators ▪ Outreach and Education ▪ Individual eligibility determinations and appeals ▪ Facilitation of enrollment in QHPs, including special enrollment periods ▪ Small business eligibility determination ▪ Facilitation of enrollment, including special enrollment periods ▪ Premium aggregation for qualified employers
Jul – Sep 2012	Eligibility System Determination: Final decisions made with respect to eligibility system upgrades and the feasibility of completing integrated system prior to Exchange launch. Contingency plan made to demonstrate significant progress in meeting eligibility system requirements. Resources involved include Medicaid, DOI, Denali KidCare, and other social service programs.
Aug 2012	Draft QHP requirements and quality monitoring processes
Sep - Oct 2012	Procurement Plan: For each function that may not be supported by current or expanded State resources, the procurement plan will identify RFI and RFP requirements, bid evaluation needs and timing, contract approval processes, project completion requirements, and an overarching quality assurance process
Sep – Oct 2012	Operational Readiness: For those resources identified in resource utilization plan, determine how many additional staff members are required to fulfill Exchange functions. Analyze how process flows will work to incorporate Exchange plan management and oversight.
Sep – Oct 2012	Revise financial sustainability plan to reflect resource utilization and staffing needs
Sep – Dec 2012	Develop and release RFIs and RFPs as applicable according to procurement plan, marketing RFP to be released in Dec.
Sep – Dec 2012	Hire and train staff as applicable

Dec 2012	Draft Navigator requirements, monitoring, oversight, and quality assurance processes
Dec 2012	Develop plan for transition from FFE to a State run Exchange, including timetable, budget, communications management, and risk mitigation strategy
Dec 2012	Draft communications and data sharing protocols as applicable for FFE time period
Feb – Apr 2013	Train Navigators on Exchange functionality, roles, responsibilities, and limitations
Mar 2013	Begin QHP application process
Apr 2013	Begin outreach campaign 6 months prior to open enrollment
May 2013	Certify qualified QHPs
May – Jun 2013	Train brokers on Exchange functionality, roles, and limitations
Oct 2013	Commence open enrollment for Federally Facilitated Exchange
Jan – Mar 2014	Revise financial sustainability plan based on current enrollment in FFE
May 2014	Beta testing of all other State-operated Exchange functionality
Oct 2014 – Jan 2015	Transition from FFE to State-operated Exchange
Oct 2015	Commence open enrollment for State-operated Exchange

3.3.4. Federally Facilitated Exchange

Despite the fact that under a full federally facilitated exchange (FFE) the State will not be required to perform any Exchange functions, implementation of an FFE will still require a strong level of coordination between the federal government and various State departments and resources, including Medicaid, DOI, and the Attorney General's Office. This coordination will ensure proper execution of eligibility determinations, data sharing agreements, and insurance product regulation.

Table 4: Implementation Plan for Federally Facilitate Exchange Option

Date	Full Federal
Jul 2012	Communicate Decision to HHS.
Aug 2012	Analyze integration points between current State processes and FFE, including insurance regulation through DOI and public assistance eligibility determinations and outreach through Medicaid, Denali KidCare, and Tribal Health Organizations.
Sep 2012	Identify additional processes, costs, and administrative expense of integration.
Oct 2012	Draft communications and data sharing protocols.
Nov – Dec 2012	Finalize protocols with HHS.
Ongoing	Meet regularly with HHS to ensure appropriate execution of protocols in the best interest of Alaskans.

3.4. Blueprint for Approval of State-Based and State Partnership Exchange

In the event the State of Alaska moves forward with implementation of a state-based, or state partnership health insurance exchange (rather than a full federally facilitated exchange), CCHIO has provided a draft blueprint for approval. To be approved, or conditionally approved, the State will need to complete and submit its Exchange Blueprint (Blueprint) that shows how it meets or will meet all of the legal and operational requirements. The Blueprint has two components: 1) a Declaration Letter; and 2) an Exchange Application.

The Declaration Letter would be submitted prior to November 16, 2012 and would contain confirmation of Alaska's intent to apply to operate a state-based or state-partnership exchange. The letter will also contain the following:

- An indication of whether Alaska intends to administer a risk adjustment program the first year of operations or whether it will use federal government services;
- An indication of whether Alaska intends to administer its own reinsurance program by establishing or contracting with a nonprofit reinsurance entity;
- An indication of whether Alaska would perform the APTC/CSR eligibility determinations or will use the federal government services for this activity;
- A designation of the individual authorized to: 1) act as primary point of contact; 2) bind the State of Alaska with HHS regarding the Exchange; and 3) sign the Exchange Application.

If Alaska decides to implement a state partnership exchange, the Declaration Letter should also contain which partnership option(s) is chosen.

If a Declaration Letter is not received by November 16, 2012, HHS will plan to implement a FFE for Alaska and will assume that: 1) Alaska will not administer its own reinsurance program; 2) the small group and individual markets will be merged in a FFE only if current markets are merged; 3) if Alaska does not merge the small group and individual markets, the SHOP will permit each qualified employee to enroll only in QHPs in the small group market; and 4) the current definition of small group employer will be followed.

The Exchange Application includes a list of activities that a state-based or state-partnership exchange must include to be approved. The list of activities includes all core functions of the exchange:

- Legal Authority and Governance;
- Eligibility and Enrollment;
- Plan Management;
- SHOP;
- Organization and Human Resources;
- Financial and Accounting;

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- Technology;
 - Privacy and Security; and
 - Oversight, Monitoring and Reporting:
 - Contracting, Outsourcing, and Agreements; and
 - State Partnership Exchange Activities.

It is important to note that the Exchange approval process outlined above is independent of the federal grants and management processes for planning and establishing a health insurance exchange. These federal grants are managed through the Establishment Review Process. Alaska has not participated in the federal grant process and, thus, is not required to participate in the Establishment Review Process to date. However, many of the requirements for the Establishment Review Process are aligned with the Exchange approval process and the federal government will streamline data collection and use information submitted for the Establishment Review Process as part of the Exchange approval process. If Alaska decides to participate in the Exchange approval process, it will not have the benefit of artifacts and documents already prepared. Thus, Alaska will need to allocate resources and time to prepare the documents and artifacts required.

3.5. Summary of Additional Recommended Analyses

Throughout Section 2.2 of this report, PCG proposed additional analyses that may support further decision making should the State of Alaska choose to pursue an Exchange. Below is a summary of those additional analyses, organized by subject area, for the State's consideration.

Governance and Administration

- Consult with stakeholder groups regarding the Exchange governance model and potential for additional advisory boards.
- Analyze legal authority of Alaska Comprehensive Health Insurance Association to determine feasibility of establishing an Exchange under that authority.

Eligibility Determination Process

- Develop a comprehensive overview of current infrastructure, applications, interfaces, and business processes that are presently used to determine eligibility for publicly-subsidized health coverage programs.
- Modify budget estimates for the design, development, and implementation of a modified eligibility engine, if necessary and appropriate.
- Modify timeline for completing the eligibility engine project to meet the January 1, 2014 effective date of coverage.

Stakeholder Engagement

- Undertake a stakeholder analysis to identify contacts within the State that may represent each of the broad categories in this list.
- Establish and execute stakeholder communication and meeting schedule.

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- Conduct a thorough analysis of stakeholder input to ensure appropriate inclusion in specific Exchange analytic and design activities.

Outreach, Education, and Enrollment

- Analyze and identify activities, organizations, and established communication networks that may be leveraged to support Exchange outreach.
- Plan Navigator program and outreach activities, accounting for vast number of languages spoken, required travel to tribal villages, and other specifics identified through stakeholder consultation and feedback.

Web Portal

- Review information available from other states, including information posted to CALT to identify public and private resources that may be leveraged to support this functionality.
- Conduct a review of existing private sector systems that currently operate in the marketplace to better understand the types of systems available, the strengths and weaknesses of these systems, and the potential to leverage existing technologies.
- Consider the necessity of issuing a new RFI for the various component pieces associated with a fully-functioning Exchange: premium generator/rating engine, premium aggregator, health benefits display and comparison, consumer decision support tools, enrollment brokerage system, and cost calculator.

Essential Health Benefit Determination

- Conduct analysis of the coverage provided by plan options, including:
 - Comparison of all benchmark options available in the State by service category; and,
 - Consideration of stakeholder input to ensure the benchmark does not eliminate or limit coverage considered essential to Alaskans.
- Conduct analysis of the cost impact on premiums for each option.
 - From the analysis, weight each of the plan options, ensuring that the final benchmark choice provides an optimal balance of cost and coverage.

Health Plan Selection and Management

If Exchange plan management functions are housed within DOI:

- Conduct operational analysis to determine whether and how many additional staff members will be required to fulfill Exchange functional requirements and which system modifications or other operational upgrades will be required to manage Exchange plans.

If Exchange plan management functions are housed within a separate Exchange entity:

- Identify how coordination between DOI and the Exchange will be achieved in order to ensure seamless application of plan management standards and avoid risk selection issues inside and outside of the Exchange.

Customer Service and Consumer Assistance

- Consider undertaking stakeholder consultation specific to customer service and consumer assistance.
- Identify and coordinate existing resources that may be leveraged to support this functionality to minimize the cost and time required to implement a successful customer service network.

Financial Sustainability

Once key decisions on leveraged resources and build-or-buy options have been made:

- Revise the financial model to fine tune expected costs and cash flows for operations.

4. EXCHANGE DESIGN OPTIONS

4.1. Administration Options

Since the passage of the ACA, HHS has firmly and consistently communicated the expectation that, as of January 2014, there will be a health insurance exchange operating in every state. The State of Alaska has begun the planning process for developing the Exchange. This planning includes the analysis and decision regarding whether Alaska is best served by a State-administered Exchange, a multi-state Exchange, or a federally-run state Exchange. The following paragraphs provide information regarding the exchange administration options.

There are three basic administration options available to the State: 1) a Statewide, State-administered Exchange; 2) a federally-run Exchange; or a multi-state Exchange. The following paragraphs describe these options and include information regarding the state-federal partnership models within the statewide state-administered Exchange that CMS proposed in September, 2011.

4.1.1. Statewide, State-administered Exchange

The option that is expected to be most commonly implemented is the single statewide Exchange. Under this option, the State would plan the Exchange independently that most appropriately serves the needs of its residents. The major advantage of this option is the autonomy of governance. All policy and procedural decision making will occur within the State.

The most commonly noted deterrent to this option is the upfront investment required to implement the Exchange, a daunting task for most states given the already tight fiscal budgets and limited availability of human capital. While the financial requirement for planning and implementation should be entirely met by available federal dollars, the challenge of this option is designing an Exchange implementation strategy that minimizes the potentially large administrative and operational burdens on the State.

4.1.2. Federally Facilitated Exchange

The ACA requires that the federal government establish and administer an exchange in those states that choose not to establish an exchange. The label of “federal exchange” can be misleading in that there will not be a single federal exchange after 2014. Any state choosing to default to federal control will still have a state exchange, but that exchange will be administered and governed by the federal government. Therefore the risk pool for smaller population states, like Alaska, will not be improved by defaulting to the federal option.

In fact, certain risks associated with the Exchange may be elevated under this option. For example, while the federal government will have control over the Exchange, the State will retain control over the market outside of the Exchange. Strong coordination between the State and federal government will be necessary to avoid risk selection issues.

States with limited resources may benefit from allowing the federal government to assume responsibility for the operational and administrative burden associated with establishing and operating an exchange. From a monetary perspective, federal funding is available to cover costs associated with planning and implementation. However, exchanges must be designed to be self sustaining by January 2015, and generating sufficient funding to support exchange operations will be an important issue for a small population state like Alaska.

CMS has introduced partnership models that states can consider instead of the federal government taking over the entire exchange operation. CMS proposes three state-federal partnership options:

1. State-operated Plan Management – Alaska would be primarily responsibility for managing the participation of health plans.
2. State-operated Consumer Assistance – Alaska would provide consumer assistance and navigation.
3. State-operated Plan Management and Consumer Assistance – Alaska can share responsibility for managing the participation of health plans or helping consumers navigate the system, or both. .

Each of the options outlined above is discussed in greater detail in Section 4.

On May 16, 2012 CCIIO provided additional guidance regarding implementing a federally facilitated exchange (FFE) The guidance document provided information regarding how the FFE will:

- Conduct Plan Management – the FFE will be limited to certification and management of participating QHPs, and does not extend beyond the Exchange or affect Alaska law governing which health insurance products may be sold in the individual and small group markets. In the FFE, CCIIO intends to certify as a QHP any health plan that meets all certification standards. CMS will release the QHP Issuer Application in early 2013 through an electronic plan management system.
- Accreditation and quality reporting requirements – ACA requires QHP issuers to implement quality improvement strategies, enhance patient safety through certain contracting requirements and publicly report quality data. ACA also requires the federal government to develop and administer a rating system and enrollee satisfaction survey system. These processes have not been developed yet, and the federal government proposes a phased process for accreditation and quality data reporting and display in the FFE. Therefore, the federal government will accept existing health plan accreditation from NCQA and URAC on issuers' commercial or Medicaid lines of business in the same state in which the issuer is seeking to offer Exchange coverage until the fourth year of certification. HHS will require that those QHP issuers without this existing accreditation must schedule this accreditation in their first year of certification and be accredited on QHP policies and procedures by the second year. By the fourth year of accreditation all QHP issuers must be accredited on the QHP product type.
- Determine eligibility - The FFE will determine individuals' eligibility for enrollment in a QHP and for APTC and CSR. The FFE will either assess or determine eligibility for Medicaid and CHIP and assist eligible individuals in comparing, selecting and enrolling

in a QHP. The FFE would use Alaska's MAGI based income standards, citizenship and immigration status and other eligibility requirements. The FFE plans to use a single streamlined application, regardless of where the consumer submits the application.

- **Agent and broker requirements** The FFE will follow state laws and regulations, and to the extent permitted by Alaska law would allow agents and brokers to enroll individuals in a QHP through an Exchange if the agent or broker ensures that the individual completes the eligibility verification and enrollment application using the FFE internet site or the agent or broker's site that meets certain conditions. In the FFE SHOP, brokers and agents and other producers will be the primary method small businesses would use to access coverage through the SHOP.
- **SHOP** - Small employers who participate in the FFE SHOP may qualify for the premium tax credit of up to 50% of the employer contribution. The FFE will adopt the state definition of the small group market in 2014 and 2015. The FFE SHOP will collect a single, aggregated payment from each employer and distribute the payment to QHP issuers based on participating employee plan selection.
- **Stakeholder engagement** – The FFE will seek input from stakeholders and provide technical support. The federal government plans to use forums and workshops to gather and provide information on implementation and operational issues. HHS will specifically consult with Alaska Natives and American Indians in the development of FFEs.

A description of the state-federal partnership options is described in the next paragraphs below.

4.1.3. State and Federal Partnership Models

State Plan Management

If the State of Alaska elects to operate the plan management function, it will work to develop health plan choices for the Exchange. This option builds upon the State of Alaska's strength and expertise within its insurance department. Plan management functions include:

- Collection and analysis of plan information;
- Plan monitoring and oversight; and
- Data collection and analysis.

HHS' role in this partnership will be to coordinate with the State regarding plan oversight, including consumer complaints and issues with enrollment reconciliation. HHS will ensure that the Exchange meets all of the required standards so consumers have access to a range of high quality plan options.

State Consumer Assistance

If the State of Alaska chooses to manage the consumer assistance functions, the Exchange will oversee in-person consumer assistance, manage the Navigator program, and conduct outreach and education. All of these functions will build on existing Alaska relationships. Other consumer assistance functions which can be more centralized, including call center operations, managing the consumer Website, and written correspondence with consumers to support eligibility and enrollment would be operated by HHS.

Both Plan Management and Consumer Assistance

If the State of Alaska elects this option, it will perform both of the above-referenced set of functions.

Multi-State Exchange

For those states that choose to establish an Exchange, a third option for consideration allows multiple states to combine forces. While the risk pools for each state exchange would not change (i.e., carriers in each state would continue to pool their individual and group market separately), similar to the federal option, there may be opportunities for increased efficiencies by combining operations. However, a true multi-state exchange requires a joint governance structure in which decision-making is entirely collaborative. Beyond the logistical issues associated with interstate collaboration, this structure is further complicated by the applicability of different insurance rules and regulations in each state. There is appeal in efficiencies and spreading risks among broader insurance pools; however, it would require extensive cooperation with multiple governors, regulatory agencies, and legislatures and would require reconciling market differences among states.

While a multi-state exchange has its drawbacks, there are opportunities to adopt a shared services model for some administrative and back-office functions required of all exchanges. Following are brief descriptions of the current federal guidance for a subset of core exchange functions that may be administered as a shared service:

- Call Center: As part of its plan to provide assistance to individuals and small businesses, the Exchange must operate a toll-free hotline to respond to requests for assistance from consumers. The Exchange needs to have a call center operational before open enrollment, but the States may want to set up these services earlier to facilitate outreach to consumers and to answer consumer questions about how the ACA may affect individual access to health insurance. While the answers that call center representatives provide may vary by state, the State may be able to realize economies of scale by sharing the infrastructure and technology needed to support the call center.
- Exchange Website and Premium Tax Credit and Cost-Sharing Calculator: The Exchange will maintain a Website through which applicants and enrollees may obtain standardized comparative information on QHPs, apply for coverage, and enroll online. The Exchange Website also needs to post required transparency information. In addition, the Exchange Website must provide access to an electronic calculator that allows individuals to view an estimated cost of their coverage once premium tax credits have been applied to their premiums, and the impact of cost-sharing reductions, if applicable. Maintaining the appearance of an individual Website for the State will be important; however, the platform supporting the Website, site maintenance and support, and operation of general features, such as the required calculators, present opportunities for efficiently sharing services.
- Eligibility Determinations: Eligibility determinations for Exchange Participation, Advance Payment of Premium Tax Credits, Cost-Sharing Reductions, and Medicaid Key operations of the Exchange will be verification and determination of eligibility for QHPs. The ACA includes requirements for these functions that will be spelled out in greater detail in future HHS guidance. Key functions within this functional area include:

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- Eligibility determinations for:
 - Advance payment of premium tax credits,
 - Cost-sharing reductions, and
 - Other applicable State health subsidy programs, including Medicaid and CHIP.
 - Appeals of eligibility determinations for enrollment in a QHP and premium tax credits and cost-sharing reductions

For example, Maryland has developed what they have termed a “point” solution for Exchange eligibility determination system based on their Healthy Maryland eligibility platform. The Healthy Maryland platform has an architecture that allows for other states to adopt the system as a whole or as a collection of usable parts. Additionally, Kansas is in the process of developing an eligibility system that may be used by other states through a purchased services model. As implementation deadlines approach, more opportunities will likely become available in this area. If the State of Alaska considers a multi-state eligibility determination system appropriate for its Exchange, the State may consider researching the platforms and eligibility systems in place and or planned for Washington, Oregon, Idaho, and California.

- Enrollment Process: The Exchange needs to facilitate plan selection for an individual who is eligible to enroll in a QHP. This includes providing information about available QHPs that is customized according to an individual’s preferences, receiving an individual’s choice of plan, and providing enrollment transactions to QHP issuers using applicable standards that will be set forth in future HHS guidance. While significant portions of the enrollment process will be State specific, the technology platform and back-office operations required to facilitate enrollment transactions represent yet another point of potential for shared services.
- Individual Responsibility Determinations and Information Reporting to the Internal Revenue Service (IRS) and Enrollees: The Exchange must have in place a process to receive and adjudicate requests from individuals for exemptions from the individual responsibility requirements of the ACA, and to communicate information on such requests to HHS for transmission to the IRS. This process of collecting and distributing exemption requests will likely follow the same business process and form of communication in every state. Additionally, the Exchange must report to the IRS and enrollees each year certain information regarding the enrollee’s coverage provided through the Exchange. Again, the same communication lines will be needed in every state, presenting opportunities for shared services.
- Administration of Advance Premium Tax Credits and Cost-Sharing Reductions: The Exchange must perform administrative activities related to premium tax credits and cost-sharing reductions. For example, the Exchange needs to communicate with HHS in situations when a person would like to report a change in income level, which may trigger redetermination of eligibility for advance payment of the credits. The Exchange is the first point of contact for prospective enrollees who will be interested in learning more about premium tax credits and for seeking assistance when needed. Similar to the individual responsibility determination, the same processes will exist for all states, as the premium tax credits and cost sharing structures will be universal.

4.2. Governance Models

Once the State of Alaska determines the question of whether to implement a State-administered Exchange, federal partnership, multi-state Exchange, or a federally-facilitated Exchange, the State will analyze and decide the governance model for the Exchange. This document provides the initial analysis for the governance options that are available for the Exchange.

4.2.1. Governance Options

The primary purpose for establishing the Exchange is to provide access to high-quality, affordable health insurance coverage. States have been given flexibility in how they design their health insurance exchanges and all states are different. The State of Alaska will consider its specific state laws, budget, and demographics as it considers the most appropriate governance model

According to the ACA “An Exchange shall be a governmental agency or nonprofit entity that is established by the State.”⁴ As expressed in the grant application materials, HHS has interpreted the law to mean that the Exchange can be operated as:

- An existing or newly created State agency;
- A quasi-governmental agency; or
- A nonprofit entity.

Of the 34 jurisdictions considering legislation establishing exchanges, four states have bills that set up the exchange under the purview of an existing state agency. The majority of states (30) have written legislation that would establish a new quasi-governmental entity with an independent governing board. Four states have legislation establishing their exchanges as a separate non-profit organization independent from state government. Several states have multiple bills with differing models for governance. The initial Alaska legislation that did not pass in 2011 was planning to establish the Exchange as a public corporation in the Department of Commerce, Community, and Economic Development, which would be considered a quasi-governmental agency.

4.2.1.1 Existing State Agency

If the State of Alaska chooses to establish the Exchange in an existing State agency, such as DHSS, the Department of Commerce, Community and Economic Development, or DOI, there are some advantages and disadvantages.

⁴ Patient Protection and Affordable Care Act, Section 1311(d)(1)

Advantages

- Existing Resources: The existing management structure and resources would be available to fill the initial roles and responsibilities. Additional staff and management would be needed as the Exchange was implemented, but this can be accomplished as part of the Exchange implementation plan.
- Access to Information and Data Sources: One of the major functions of the Exchange will be to determine eligibility and promote enrollment. If the Exchange is housed in an existing public agency, access to the eligibility and enrollment data may be expedited.
- Public Contracting Authority: A public agency will have the procurement authority and vehicle for planning and implementation vendor contracts. This advantage may also be considered a disadvantage because the Exchange will be constrained by the procurement timelines and requirements and this may impede timely progress toward implementation.
- Public Agency Labor Protections: An Exchange that is formed within a public agency will be subject to all the state hiring, worker protection and safety laws. This advantage may also be considered a disadvantage, particularly if the State is subjected to hiring freezes, protracted hiring processes, and limits to compensation.

Disadvantages

The disadvantages relate primarily to the ability of the Exchange to be developed and implemented quickly and within the aggressive timelines provided in the ACA:

- The State agency may not have current managerial or staffing capacity to develop and implement the Exchange.
- A conflict of interest may be created if the Exchange is operated within the DOI because of the insurance regulatory role to assure financial soundness of insurance organizations within the State. If the DOI houses the Exchange it will have the responsibility for assuring that the Exchange has qualified health insurance plans. This role of potentially negotiating with insurance companies and the role of regulator may conflict.
- Maintenance of Exchange leadership – If the Exchange is within a State agency, the leadership may change as the state administration changes.

4.2.1.1 New State Agency

Advantages

- A new State agency will have independence from existing agencies and will be able to establish an agency mission that is solely the Exchange functions.
- Same application of State laws regarding procurement and labor.

Disadvantages

- Implementation of a new agency with staff will take significant time to implement.
- Maintenance of Exchange leadership – If the Exchange is within a new State agency, the leadership may change as the state administration changes.

4.2.1.1 Quasi-Governmental Agency

A quasi-governmental agency is one that is established through legislation or other law and has State oversight. This means that the organization is established and leadership appointed by the State. These organizations are not directly under the control of the governor and are not constrained by State hiring and procurement laws. Examples of quasi- governmental health insurance exchanges include the Massachusetts Connector and the California Health Benefit Exchange. Both of these Exchanges were created by state statute with specific authority for exchange functions and administration of the exchange.

Advantages

- Flexibility to design its administrative processes, such as hiring and procurement.
- Still affiliated with the government and may likely have access to information databases for streamlining eligibility and enrollment. This will allow this type of organization to hire qualified individuals more quickly and become engaged in the business of the Exchange more timely.

Disadvantages

- Brand new organization needs to be built and implemented. This will include developing working relationships with other agencies and stakeholders.
- May be expensive to set up the infrastructure of the Exchange – staffing, office space, and other investments.

4.2.1.1 Creation of a Nonprofit Organization

Advantages

- Flexibility – same as quasi – governmental agency.
- Not constrained by changes in administration.

Disadvantages

- Lacks accountability – may not have the same requirements for financial accounting and transparency (open meeting laws, etc.). This disadvantage can be eliminated by requiring the nonprofit organization be subject to Alaska open meeting laws.
- Not have easy access to public databases. For example, a nonprofit may have difficulty accessing tax database, social security database, etc. This disadvantage can be eliminated by careful legislative drafting that addresses how the Exchange will access these necessary databases.
- No pre-established relationships with government agencies. This disadvantage can be minimized by requiring the Exchange to establish and coordinate activities with public agencies.

4.3. Actuarial Analysis

The Actuarial Analysis is included in this report as Appendix B.

4.4. Program Integration

4.4.1.1 Eligibility

The creation of the Exchange in Alaska will greatly affect the way private and public health insurance is understood, applied for, received, utilized by citizens, and regulated in the State.

The ACA requires the State to establish a single, streamlined eligibility and enrollment process that will serve as the central point of access to publicly subsidized health coverage programs, including Medicaid, CHIP, and the Exchange. Instead of requiring submission of separate or different applications, the State of Alaska needs to develop a streamlined, simplified, user-friendly approach that enables consumers to use a single application for eligibility and enrollment in Medicaid, Denali KidCare, and the Exchange. The ACA also requires that the Secretary of HHS develop and provide to each state a single, streamlined form that may be used to apply for advance payments of the premium tax credit, cost-sharing reductions, Medicaid, CHIP, and the Basic Health Plan, if the Basic Health Plan is operating in the exchange service area. The ACA requires this form to be structured to maximize an applicant's ability to complete the form satisfactorily, taking into account the characteristics of individuals who qualify for the programs.

In other words, the ACA's so called "no wrong door" mandate will bring programs and State government entities together that did not necessarily previously interact with each other. These entities and programs include:

Table 5: State Agency Roles in the Exchange

Agency/Division	Area of Importance
DOI in the Department of Commerce, Community, and Economic Development	DOI regulates health insurance in the state. DOI will have a key role in plan management and regulation and could potentially certify plans as QHPs for the Exchange
Medicaid Agency in DHSS	Medicaid expansion is a key part of the ACA, eligibility determinations will have to occur for Medicaid either through the Exchange Website, or via the Exchange Website referring applicants to Medicaid's eligibility determination.
Division of Public Assistance in DHSS	The Division of Public Assistance runs programs such as the State's Food Stamps program which must be part of the "no wrong door" eligibility determination process. The Division of Public Assistance also runs the Alaska Temporary Assistance Program, the State's version of the federal TANF block grant.

Agency/Division	Area of Importance
Denali KidCare (CHIP) in DHSS	Denali KidCare provides health insurance coverage for children and teens through age 18, and for pregnant women who meet income guidelines. These guidelines exceed the FPL for the Medicaid expansion under the ACA and thus separate eligibility determinations will be required for KidCare. This determination will also have to be made through the no wrong door approach.

To support eligibility determinations for the Exchange, the State of Alaska will likely to have to build and implement a new eligibility rules engine as a new component of the State's eligibility environment. The eligibility engine could be a standards-based business rules and technology-neutral repository that can be easily accessed to determine eligibility for the Exchange, Medicaid, Denali KidCare, and other State programs. The need for a new system is predicted based on interviews with state officials and discussed in more detail later in this report

The ACA requires a state-based exchange to offer consumers multiple access points to apply for coverage with eligibility for all publicly subsidized medical assistance programs based primarily on the applicant's MAGI. The rule requires that an individual must be able to file an application online, by telephone, by mail, or in person.

Currently, the State of Alaska determines eligibility using the State's Eligibility Information System (EIS), which is run by the Division of Public Assistance inside of DHSS. EIS is a legacy from the early 1980s. It was the first system built with federal funding to determine eligibility for a wide variety of programs. The system determines eligibility for an array of programs, including, but not necessarily limited to:

- Medicaid & CHIP (Denali KidCare)
- SNAP (aka food stamps)
- TANF
- State Supplement to SSI (adult public assistance)
- Additional state specific programs

While EIS has aspects of a "no wrong door" system since it determines eligibility for an array of State programs, the system has a number of limitations when its use for an Exchange is considered. Representatives at DHSS report that, as it stands, the State would have a very difficult time interfacing EIS with a new Exchange system. Simply put, the current system is not modular and is 30 years old. EIS is not effective at "noticing" and new interfaces have to be constructed which is a lengthy and labor intensive process. According to rules implementing the ACA, amongst the many new requirements of the

law, Medicaid systems will have to “produce notices and communications to applicants and beneficiaries concerning the process, outcomes, and their rights to dispute or appeal.”⁵

In addition, EIS does not have any online abilities, an online application, and or an easy client portal. Building client interaction into the system would be inefficient and possibly ineffective. It does not appear that the EIS system can be transformed into the public interface for applying for public programs imagined by the ACA.

In addition, the ACA mandated new income definition – MAGI – for determining Medicaid income eligibility. The adoption of MAGI, which is based on adjusted gross income as defined in the Internal Revenue Code §36B(d)(2), will standardize the calculation of income across the nation. Additionally, since income will be based on an income tax definition, family size, and household income will be based on tax filing unit, which is another change from the current methodology used by Medicaid. The EIS system likely cannot handle the change to MAGI standards, and a new eligibility engine will likely be required.

The State of Alaska contracted with a consulting company to analyze the cost of a new system, but the study focused on a new EIS system more than it did on the Exchange system. While it is expected that any new EIS system would have the ability to interface with Exchange systems, the study was not performed with the Exchange system in mind.

One possible solution could be to use the State’s “myAlaska” portal (<https://my.alaska.gov/>) and push applications to EIS. MyAlaska is a portal that citizens register for in order to receive easier access to State services. It can be used to apply for electronic pay records, register vehicles, apply for fishing licenses and also the state’s permanent fund dividend. However, it is likely that this would not be a long term solution.

The State of Alaska needs to determine if it wants to build one system for both the Exchange, EIS, and MAGI standards, or if it will create separate systems that interface with each other.

As the State considers either tailoring current systems or developing a new eligibility engine that will serve as the single, streamlined eligibility process for all medical assistance programs (including Medicaid, Denali KidCare, and the Exchange), coordination will have to take place between Division of Public Health and Division of Public Assistance at a minimum.

DOI, inside of the Department of Commerce, Community, and Economic Development is another key agency that must be integrated into Exchange operations. DOI does not currently have any formal interaction with the Division of Health or Public Assistance, and new ties would be developed through the Exchange.

⁵ <https://www.federalregister.gov/articles/2011/04/19/2011-9340/medicaid-program-federal-funding-for-medicare-eligibility-determination-and-enrollment-activities#p-13>

DOI is currently tasked with regulating health insurance in the State, and providing for efficient processes to enroll users in health plans is a key function of an Exchange. An Exchange must facilitate plan selection for individuals who are eligible to enroll in QHPs. This function includes: 1) providing information about available QHPs that are customized according to an individual's preferences; 2) receiving an individual's choice of plan; and 3) providing enrollment transactions to QHP issuers.

To support enrollment functions, the Exchange requires core information technology infrastructure and business processes that will effectively and efficiently enroll people in health coverage. DOI currently leverages the National Association of Insurance Commissioners' System for Electronic Rate and Form Filing (SERFF) for plan management functionality. SERFF is in the process of being updated for Exchange functionality, and DOI will likely continue to use SERFF in the future.

Exchange staff should work with DOI to understand the information currently provided by carriers as part of DOI's regular filing requirements (including through SERFF), and compare the current filing requirements to the data and information that needs to be provided by health insurers that wish to offer coverage through the Exchange. For those Exchange filing requirements that are not currently captured by DOI, the State should consider whether to modify the current filing requirements to satisfy the ACA requirements or whether the Exchange needs to request carrier information that supplements the information being provided to the DOI.

The Exchange and DOI will also need to develop a protocol for transferring information that will be used by the Exchange to determine if a carrier meets the QHP issuer certification requirements.

Seamless integration is important because significant numbers of individuals may transition over time between Medicaid, Denali KidCare, and subsidized coverage under the Exchange as income fluctuates. The Exchange and DHSS should design business processes and technical system supports that work effectively across the different forms of insurance.

The DOI can likely continue to perform functions it is currently responsible for, as well as some new ones, after an Exchange is established in order prevent duplication of effort and save costs. These functions include certifying insurers are in good standing to offer products in the State, working to determine QHP approvals, and working with consumer to discuss health insurance rates.

4.4.1.1 Education, Outreach, Enrollment

As discussed briefly in the Roadmap earlier in this report, the ACA and subsequent regulations (in both final and proposed form) identify a broad range of consumer assistance tools and programs for the Exchange. The State of Alaska needs to develop a multi-pronged outreach, education, and enrollment program, which will include coordinating the customer service units/call centers for these programs and defining the role of Navigators and brokers. Effective education and outreach for the Exchange are critical considerations. In addition to coordinated eligibility processes and a "no-wrong-door" approach, consumers need help assessing coverage options and completing enrollment.

The State of Alaska needs to undertake a multi-pronged outreach, education, and enrollment effort for the Exchange. Separate from the implementation of a Navigator program (described later in this report),

rules requires that Exchanges conduct outreach and education activities to educate consumers about the Exchange and encourage participation. Outreach, education, and enrollment efforts will likely involve a number of public and private organizations and individuals, including the Exchange, DHSS (both Medicaid and Public Assistance), DOI, other State and county social service agencies, and a number of community-based entities. The required outreach effort might include a number of channels: public schools; faith-based organizations; residential facilities; hospitals; community health centers; physicians; and other human services programs that currently participate as Medicaid providers.

The State's rollout of Denali KidCare may provide a useful example for the Exchange's marketing efforts. When the program began in 1999, the Division of Public Health conducted a significant education program, including specialists in the field, to educate the public about the program and encourage enrollment. Specialists were placed in the field (not unlike Navigators) to work directly with people in their communities. As Denali KidCare will be a component of programs included in the coverage that can be received through an Exchange, representatives from the program with direct knowledge of this past effort could provide key expertise to how to efficiently and successfully market the Exchange.

In addition to consumer outreach, the ACA requires the Exchange to operate a toll-free number for requests for assistance by consumers. Rules require a call center to assist individuals with eligibility, enrollment, and benefits questions via a toll-free telephone number, but provide significant latitude in how the call center is structured. CMS believes that the Exchange call center should have the capability to provide assistance to consumers and businesses on a broad range of issues, including, but not limited to:

- The types of QHPs offered in the Exchange;
- The premiums, benefits, cost sharing, and quality ratings associated with the QHPs offered;
- The categories of assistance available, including advance payments of the premium tax credit and cost-sharing reductions as well assistance available through Medicaid and Denali KidCare; and
- The application process for enrollment in coverage through the Exchange and other programs (for example, Medicaid and Denali KidCare).

The State of Alaska needs to determine whether to utilize: 1) a single call center to handle both eligibility and health plan enrollment questions and inquiries; 2) separate call centers – one to handle eligibility questions and a second to handle health plan enrollment and health benefits questions that are specific to the Exchange to support eligibility and enrollment; or 3) a single call center to support both activities. The Exchange, DHSS, and perhaps DOI needs to work closely to determine whether existing call center resources can and should be leveraged, even in an overflow capacity, and what protocols for referrals and warm transfers between call centers need to be established. Regardless of the final configuration, the call center(s) must be prepared to manage an unprecedented array of questions and be able to answer, or efficiently direct the caller to the correct destination.

To this end, it may be possible to expand on current efforts underway at the DOI. DOI has a consumer services section that handles consumer complaints and inquires that could possibly perform similar functions for Exchange plans. However, current systems would undoubtedly have to be expanded for full Exchange functionality.

4.4.2. Navigator Program

As discussed in the Roadmap, in addition to establishing a Website, a customer service unit, a call center, and walk-in centers to help people with the eligibility and enrollment process, the ACA requires the Exchange to contract with outside entities (i.e., “Navigators”) that can assist individuals with eligibility and enrollment for all health coverage programs. Navigators are entities that can provide information to individuals about health coverage options and help them enroll in a health plan or in other publicly subsidized health coverage programs. These entities can be: 1) trade, industry, and professional associations; 2) chambers of commerce; 3) unions; 4) community based non-profit groups; or 5) other groups that have established or can readily establish relationships with employers, employees, consumers, or self-employed individuals.

The Exchange needs to establish a selection process for awarding grants or contracts to Navigators. To reach the thousands of Alaskans who will become newly eligible for Medicaid or subsidized coverage through the Exchange, the State of Alaska needs to expand outreach efforts to leverage many of the community organizations and provider groups traditionally involved with Medicaid and Denali KidCare.

Specifically, the Exchange, in coordination with Medicaid and other DHSS divisions, may want to establish a selection process for awarding grants to Navigators to assist with outreach, eligibility, and enrollment for Medicaid, Denali KidCare, and subsidized insurance available through the Exchange.

The approach to selecting Navigators should take into account the relationship between medical assistance programs like Medicaid and subsidized insurance available through the Exchange. Different populations will now be screened and eligible for all publicly subsidized insurance coverage. The Exchange, in coordination with DHSS divisions, may want to establish a selection process for awarding grants to Navigators to assist with outreach, eligibility, and enrollment for Medicaid, Denali KidCare, and subsidized insurance available through the Exchange. Leveraging the experience and expertise of various parties (including State agencies, county social service agencies, community-based organizations, and other entities) will be crucial in developing an efficient and effective outreach, education, and enrollment program.

The ACA requires that plans, including QHPs, use a uniform format, uniform definitions of insurance and medical terms, and understandable terminology to describe benefits and coverage. The Secretary of HHS is charged with development of the standard definitions for: 1) insurance-related terms (such as coinsurance, co-payments, out-of-pocket limits, preferred provider, grievances, and appeals); medical terms (such as hospitalization, hospital outpatient care, emergency room care, home health care, medical equipment and emergency medical transportation); and “such other terms as the Secretary determines are important to define so that consumers may compare the medical benefits offered by health insurance and understand the extent of those medical benefits (or exceptions to those benefits).”

The Exchange must develop written notices and other forms to ensure that applicants, qualified individuals, and enrollees understand their eligibility and enrollment status. Rule will require all applications, forms, and notices be provided in plain language. In addition, applications, forms, and notices should be written in a manner that meets the needs of diverse populations by ensuring effective communication for people with disabilities and providing meaningful access to limited English proficiency individuals.

Additionally, the HHS's Office for Civil Rights mandates that any entities receiving federal funds, including health care organizations (e.g., through Medicaid or CHIP), "must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation."

All service providers, including managed care plans, must maintain a list of in-house and/or community based sign language interpreters. This list must be reviewed, at least annually, and revised, if necessary. Facilities must also have policies outlining how individuals with hearing impairments are identified as needing interpretation services, and how these services can be accessed at no cost to them.

The Exchange should incorporate contractual requirements for QHPs, Navigators, and brokers to address enrollment of individuals with limited English proficiency and ensure effective communication for individuals with disabilities.

4.4.3. Participating Health Carriers

The ACA requires the Secretary of HHS to establish minimum certification requirements for QHPs that participate in exchanges. The ACA makes the Exchange responsible for certification and monitoring of QHPs. However, the ACA does not displace state insurance regulations, nor do exchanges replace insurance departments. Without question, the Exchange needs to work very closely with DOI on issues related to plan management function of the Exchange.

The ACA requires the Exchange to make available QHPs it has determined are "in the interests of consumers and employers." Accordingly, the Exchange needs to establish process and selection criteria to determine which health plans it will make available. Because the Exchange is responsible for certifying QHPs, a policy consideration for both the Exchange and the State's Medicaid administrators is the extent to which each program will attempt to encourage health carriers to serve both markets.

This may be a difficult challenge for the State of Alaska, as it is one of the few states in the nation that does not have any of its Medicaid population in private, Medicaid Managed Care Organizations. However, the State may want to consider some method to help coordinate care for individuals who move between these public and private programs due to income fluctuation.

One possible way to reduce fluctuation for people moving between the programs is in the provider networks QHPs are required to maintain. QHPs could be required to have a certain number of Medicaid providers inside of their networks of doctors. This would increase the likelihood that individuals who move from Medicaid to subsidized insurance through the Exchange could maintain their existing relationship with their doctors. Provider networks will be explored in more detail in the next section.

The ACA additionally requires health insurers that offer QHPs through the Exchange to meet established marketing standards. A key consideration in the development of any marketing standards for QHPs is the extent to which Exchange standards may differ from the marketing standards in place for all commercial insurers operating in the Alaska market, as regulated by the DOI.

DOI has responsibility for overseeing the marketing and distribution of health insurance in the State of Alaska. The Exchange should review DOI's current marketing standards to determine whether the existing standards will be adequate for the population served through the Exchange.

The ACA requires the Exchange to maintain an Internet Website through which consumers can get standardized comparative information on plans. Exchanges also must assign a rating to each QHP offered in accordance with criteria developed by the Secretary of HHS. While future federal rulemaking is anticipated on a system that rates health plans on the basis of their relative quality and price, it is clear that the Exchange can have a role in the implementation, oversight, and improvement of the quality and enrollee satisfaction initiatives required by the ACA.

In addition to assigning a quality rating to each QHP offered, the rule requires that the Exchange evaluate quality improvement strategies and oversee implementation of enrollee satisfaction surveys, assessments, and ratings of health care quality and outcomes, information disclosures, and data reporting.

QHPs are required to: 1) implement and report on a quality improvement strategy or strategies; 2) disclose and report information on health care quality and outcomes; and 3) implement appropriate enrollee satisfaction surveys. QHPs' strategies should be consistent with an overall rewards quality through reimbursement and incentives for improving health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, medication, and care compliance initiatives. Quality improvement by QHPs must address specific requirements for enhancing patient safety beginning in January 2015.

The ACA requires an exchange to establish and operate an Internet Website no later than January 1, 2014 that is linked to the Exchange, Medicaid, and CHIP agencies. Rules require that an exchange maintain an up-to-date Internet Website that presents standardized comparative information, including quality ratings, on each available QHP.

To promote a viable and sustainable market, the ACA requires the development of a number of financial management capabilities and functions related to an exchange's financial sustainability and program integrity. The breadth of the program integrity provisions in ACA is significant. There is an increase in scrutiny of entities that participate in federal health care programs, as well as an increase in data sharing and coordination requirements intended to identify fraudulent schemes and actors. Participants in the Exchange have regulatory requirements for program integrity and the prevention of fraud, waste, and abuse. In addition, the Exchange has its own expressly stated financial and program integrity and oversight requirements. The Exchange will indirectly monitor the program integrity functions of the participants related to exchange activities. This monitoring will enable the Exchange to be responsive to the U.S. Government Accountability Office as it undertakes the study of the cost and affordability of QHPs offered through exchanges.

As part of its oversight and program integrity program, the Exchange needs to complete data sharing agreements and memoranda of understanding with DHSS (for Medicaid and Denali KidCare), as well as DOI. These agreements will memorialize the understanding of the roles of each of the Exchange participants, as well as a clear statement of the obligations of each participant. The Exchange should engage Medicaid for concrete and practical resources to combat fraud and abuse. The Exchange should leverage, to the greatest extent possible, the experience, tools, training, and other resources of participants to protect the financial integrity of the Exchange from fraud and abuse.

4.4.4. Essential Health Benefits

As briefly discussed in the Roadmap, the ACA requires exchanges to offer QHPs that cover EHBs, which are described in broad terms in the ACA. The law lists the following categories of services that must be covered as part of the EHB package:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance abuse services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

The ACA directs the Secretary of HHS to provide additional details on the benefits and services to be covered under the EHB, which must equal the scope of benefits provided under a “typical employer plan.” In defining these benefits, the law directs the Secretary to establish an appropriate balance among the benefit categories and requires that the benefits must not be designed in ways that discriminate based on age, disability, or expected length of life, but must consider the health care needs of diverse segments of the population.

On December 16, 2011, the Secretary issued a bulletin that describes HHS’ proposed approach with regard to the EHB requirements. The Secretary’s proposed approach seeks to balance comprehensiveness, affordability, and state flexibility by allowing each state to set an essential health benefits package that reflects plans typically offered by small employers and benefits that are covered across the employer marketplace.

HHS proposes that each state be allowed to utilize a benchmark plan selected by the state to define what is included under the state’s essential health benefits package. For 2014 and 2015, the Secretary proposed

that the following four plan types may be used by states as benchmarks in designing essential health benefits:

1. Largest plan by enrollment in the state's small group market;
2. Any of the largest three state employee health benefit plans by enrollment;
3. Any of the largest three FEHBP options by enrollment; or
4. The largest insured commercial, non-Medicaid HMO operating in the state.

"The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a 'typical employer plan' in that state as required by section 1302(b)(2)(A) of the Affordable Care Act."

Accordingly, the State of Alaska needs to select a benchmark plan to serve as the standard for QHPs offered through the Exchange and all other (non-grandfathered) health plans offered in the individual and small group markets. In addition, the EHB package may need to be offered to Medicaid recipients who become newly eligible under the 2014 Medicaid eligibility expansion. If the State does not select a benchmark plan, HHS has proposed that the default benchmark plan will be the largest plan by enrollment in the State's small group market, as of the first quarter of calendar year 2012. Because certain EHB categories of service (e.g., pediatric vision and oral care, habilitative services) are not typically covered in commercial health insurance plans, the State needs to supplement the chosen benchmark plan to include all of the required ACA categories of services.

HHS intends to re-assess the benchmark plan process for calendar year 2016. At that time, it is likely that HHS will further define the essential health benefits, which could result in the state needing to revise the EHB package.

Section 1311(d)(3)(B) of the ACA requires the State to defray the costs of State-mandated benefits in excess of the EHBs for individuals enrolled in any QHP through the Exchange either in the individual market or in the small group market. According to HHS, the approach for 2014 and 2015 provides a "transition period for states to coordinate their benefit mandates while minimizing the likelihood the state would be required to defray the costs of these mandates in excess of EHB. In the transitional years of 2014 and 2015, if a state chooses a benchmark subject to state mandates – such as a small group market plan – that benchmark would include those mandates in the state's EHB package."

Alternatively, the State could select a benchmark such as an FEHBP plan that may not include some or all of the State's benefit mandates, and therefore under Section 1311(d)(3)(B) the State would be required to cover the cost of those mandates that exceed the State EHB package. HHS intends to evaluate the benchmark approach for calendar year 2016 and will develop an approach that may exclude some State benefit mandates from inclusion in the state EHB package.

Based on this guidance, which has not yet been formalized through the regulatory process (and is subject to change), the State of Alaska would not be required to pay the cost of State mandates that may have exceeded a federal definition of the EHB package, assuming the State chooses a benchmark plan for 2014

and 2015 that includes all State mandated benefits. However, the State will still need to determine the EHB package for Alaska for plan year 2014 or default to the benchmark plan selected by HHS (i.e., Alaska's small group market plan with the largest enrollment).

Because the EHB applies to all plans sold in the individual and small group markets, and not solely to plans sold through the Exchange, the State should consider establishing a multi-agency task force, including representation from the Exchange, the DOI, DHSS, executive and legislative leaders, as well as key private sector stakeholders, to compare and contrast the four benchmark plan types that may be chosen as the EHB for Alaska. A decision regarding which benchmark plan to use needs to be finalized by the fall of 2012 to allow insurers sufficient time to modify their plan designs, if necessary, to reflect the state's EHB requirements.

Subsequent to its decision regarding the EHB package, the State should also consider assessing the potential cost of State mandated benefits that may exceed the federal government's definition of EHBs, based on EHB limits that HHS may impose for plan year 2016.

4.4.5. Provider Networks

The ACA requires the Exchanges to establish network adequacy standards. Rules will likely require the Exchange to ensure that enrollees of QHPs have a sufficient choice of providers. QHPs must comply with any network adequacy standards established by the Exchange. The broad standard in the rule affords the Exchange significant flexibility developing QHP network access standards to QHPs in a manner appropriate to the State's existing environment.

A consideration in the development of network adequacy standards for QHPs is the extent to which the Exchange network adequacy standards should apply to all commercial insurers operating in the State of Alaska. The Exchange needs to develop standards, likely in concert with the DOI. Another key consideration is the extent that Exchange standards align with network access requirements for Medicaid and Denali KidCare.

As previously mentioned, the Exchange may want to consider mandating that QHPs have a certain percentage of providers who accept Medicaid in their networks. This would allow those who move from Medicaid to subsidized insurance based on income level to maintain the same doctor as they move from public to private insurance.

The ACA further requires that a QHP's network include essential community providers who provide care to predominantly low-income and medically-underserved populations. Essential community providers include entities specified under section 340B(a)(4) of the Public Health Service Act and section 1927(c)(1)(D)(i)(IV) of the Public Health Service Act as set forth by section 211 of Public Law 111-8. These organizations are either non-profit or government entities that provide services to predominantly low-income and medically-underserved populations. Section 1927(c) of the Social Security Act requires pharmaceutical manufacturers to pay rebates for covered outpatient drugs that are dispensed to Medicaid patients. The 340B program is a federal drug discount program that was established in 1992. Section 340B of the Public Health Service Act limits the cost of drugs to certain grantees of federal agencies and

other entities identified in the statute to provide significant savings on pharmaceuticals for those entities that participate in this program. Entities eligible to participate in this program have included: 1) federally qualified health centers (FQHCs); 2) FQHC look-alikes; 3) Disproportionate Share Hospitals; 4) Family Planning Clinics; 5) HIV/Ryan White Clinics; 6) state-operated AIDS Drug Assistance Programs; 7) Black Lung Clinics; and 8) urban Indian organizations receiving funds under title V of the Indian Health Care Improvement Act; section 7101 of the ACA expanded the entities that qualify for the 340B program to: 9) children's hospitals who are excluded from the Medicare prospective payment system; 10) free-standing cancer hospitals who are excluded from the Medicare prospective payment system; 11) critical access hospitals; 12) rural referral centers; and 13) sole community hospitals that have a disproportionate share adjustment of eight percent or more. The regulations for network adequacy require QHP issuers to "include in their provider networks a sufficient number of essential community providers, where available, that serve low income, medically-underserved individuals."

Rule making will also require QHPs to make a provider directory for a QHP available to the exchange for publication online pursuant to guidance from the exchange and to potential enrollees in hard copy upon request. In the provider directory, a QHP must identify providers that are not accepting new patients.

Coordination between the Exchange and Medicaid could also be helpful in addressing essential community providers.

5. COMMUNICATION PLAN

The Exchange project Communication Plan defines the project's structure and methods of information collection, screening, formatting, and distribution of project information. It also outlines and defines a mutual understanding among project teams in regard to the actions and processes necessary to facilitate the critical links among people, ideas, and information that is necessary for project success. At a high level, the Communication Plan will define the content and substance of the objectives mentioned above and confirms that it has been properly conveyed as follows:

- Determine communication requirements based on the roles identified.
- Ascertain what information will be communicated and to whom.
- How will this information be communicated to others?
- When will it be disseminated and who will be responsible for substantiating that the process has been completed?
- Who sends the data and how is receipt of the data confirmed?

The communication approach is tailored to provide the appropriate level of communication for each project stakeholder group, with different information and frequency of communications for each group. Multiple vehicles of communication may be utilized for each instance. The leadership team may work with the Center for Consumer Information and Insurance Oversight (CCIIO) to explore using a central documents repository such as the Collaborative Application Lifecycle Tool (CALT) and/or Microsoft SharePoint to facilitate communication among all team members.

All project communication activities will be based on the Communication Plan, with a matrix of specific actions addressing communication needs of each stakeholder group. The Communication Matrix will be used to define details regarding the communications activities that are used during the course of the project. The Communication Matrix will be further developed and maintained by the project manager. The project team may work together with CCIIO to develop this matrix of communication activities around each major project milestone. The final Communication Plan will adhere to existing policy within DHSS to the greatest extent possible regarding the development, review, approval and release of information to the general public and media.

5.1. Objectives

The objectives of the Communication Plan include:

- Ensuring that needed information is available to project stakeholders in a timely manner;
- Collecting and distributing project performance information, such as status reports, progress measurement and forecasting;
- Establishing a central contact point and/or forum for information dissemination;

-
- Managing communications to satisfy project stakeholder requirements and resolving any unresolved issues pertaining to stakeholders; and
 - Ensuring that stakeholders input is collected, assessed, and incorporated into the overall program implementation as appropriate.

5.2. Stakeholder Identification

Key external stakeholder groups that have previously been engaged through large group-specific meetings include:

- Insurance brokers and agents;
- Health care providers;
- Tribal health organizations and tribal representatives; and
- Health insurance issuers.

These groups were engaged directly by DHSS to participate in a broad, level setting discussion regarding health insurance exchanges and State options with respect to potential implementation. The insurance broker group indicated that Greg Loudon, working through the legislative committee, may act as the liaison to the rest of the group when information must be disseminated and comments must be received quickly. The tribal organizations recommended using Medicaid's current tribal consultation process to continue stakeholder engagement with this group.

The project also includes a variety of "internal" and project team stakeholders. These entities include but are not limited to:

- State agency and division project partners (DHSS, Division of Insurance (DOI), Medicaid, Denali KidCare, Tribal partners);
- The Governor and the State Legislature;
 - Federal Exchange (CCIIO and the Center for Consumer Information and Insurance Oversight (i.e, CMS), as applicable; and
- Independent consultants, as applicable.

In addition to those groups who have already been identified or engaged at some level, other key stakeholder groups and specific organizations include:

- Small business owners and self-employed individuals, including those with seasonal or part time workers and chambers of commerce where applicable;
- Individual insurance consumers;
- Organizations with experience facilitating enrollment;
- Advocates for hard-to-reach populations;
- Non-profit consumer advocacy organizations and research groups, such as Consumer Action and the Alaskan Public Interest Research Group;

- Public health experts; and
- Large employers, including those with seasonal workers or a majority part-time workforce.

5.3. Two-Way Communication Strategy

5.3.1. Dissemination of Information from the State

At the initial outreach effort regarding the Exchange, Alaska's first priority should be to engage in level setting educational activities with stakeholder groups and the general public. These activities will aim to dispel misinformation with respect to the Exchange and provide a uniform foundation on which to build a dialogue with stakeholders and the public. Other states have utilized a variety of outlets for this exercise, including town meetings, issuance of issue briefs, and frequently asked questions (FAQs), and inclusion of health insurance exchange discussions in related committee meetings.

For Alaska, a draft educational outreach plan is included below:

Table 6: Draft Educational Outreach Plan

Activity	Targeted Stakeholders	Channels	Timeframe
Town meetings	Identified stakeholder groups and general public.	Meetings to be located in four largest population areas, teleconferencing used where available.	July 2013 – December 2013
Issue Briefs regarding specific Exchange subtopics, e.g. consumer assistance resources for Exchange consumers	Some issue briefs may be targeted to specific groups, others will support general knowledge.	DHSS Website	Quarterly through Exchange planning time period
FAQs from town meetings and other communication channels	All stakeholders and general public.	DHSS Website	Quarterly through Exchange planning time period, or as applicable
Related Committee Briefings	Stakeholders currently engaged in other committees related to health care in the State.	Health Care Commission	July 2013 – December 2013, as available
Email listserv	All stakeholder and general public.	DHSS	Monthly updates on Exchange planning

5.3.2. Collection of Input from Stakeholders

Meeting Minutes

As an initial step in collecting stakeholder feedback, minutes will be recorded at each town meeting with comments, questions, and suggestions organized by topic area.

Inbox

A State-based e-mail inbox will be established to collect questions and comments related to the issue briefs, as well as general concerns. The e-mail address will be included in all issue briefs and other press releases.

Focus Groups and Individual Meetings

As the State progresses deeper into the planning process, detailed input will be required from key stakeholders, including consumer organizations and insurance issuers. Focus groups of ideally no more than ten individuals and individual meetings, as needed, will be organized to address specific planning activities and stakeholder concerns.

Ongoing Dialogue

A contact person designated at DHSS will act as the main liaison to stakeholders regarding Exchange planning. This individual will be responsible for receiving specific planning and operational information from stakeholders that may be confidential or otherwise sensitive in nature.

5.4. Strategy for Managing Project Communications

The Communication Matrix will be used to manage a majority of the project communication activities and completed by the project manager. This framework, which will be based on further stakeholder analysis, will help to consolidate and standardize communication activities with both internal and external stakeholders. The Communication Matrix will provide the following:

- What will be communicated (message)
- Who will develop each type of communication (author)
- Who will approve the communication (approver)
- Who is the target receiver/consumer of the message (target)
- How will it be communicated (format)
- How will the message be distributed/delivered (channel)
- When will it delivered (schedule)
- What is the frequency of the communication (frequency)

Table 7: Communication Matrix

Message	Author	Approver	Target	Format	Channel	Schedule	Frequency

5.5. Incorporation of Stakeholder Input into Planning Process

All stakeholder input received through the above described processes will be categorized by topic area and disseminated to the appropriate contact person as a monthly report. Major planning areas to be designated by the State will include:

- Eligibility;
- Enrollment;
- Financial Planning;
- Program Integration;
- Outreach and Education;
- Consumer Assistance and Customer Service;
- Plan Management; and
- Program Integrity.

6. FINANCIAL SUSTAINABILITY

As currently written, the ACA requires the Exchange to be self-supporting by 2015, meaning that the total operating costs of the Exchange must be paid by revenues generated on behalf of the Exchange. This requirement applies whether the State or the federal government operates the Exchange.

In its analysis of the Exchange financial sustainability options, PCG has identified a number of potential revenue streams that could support Exchange operations while containing costs to users of the system and thus minimizing the cost burden on citizens of the State of Alaska.

This section of the report aims to first discuss the potential revenue options and then analyze each one in order to determine the most viable option(s) for the State of Alaska. Viability will be measured according to several factors:

1. Potential revenue;
2. Operational feasibility; and
3. Potential risks.

6.1. Revenue Options

PCG's research has identified a number of different revenue options the Exchange can utilize outside of receiving general funds. The following chart lists these options and provides a brief summary of each one:

Table 8: Exchange Revenue Options

Funding Source	Summary
QHP Administrative Fees	An administrative fee charged on plans sold through the Exchange, paid for by the plans.
Consumer Administrative Fees	An administrative fee paid by those who purchase insurance through the Exchange.
Accreditation Fees to Agents and Brokers	A fee insurance agents and brokers would have to pay to sell insurance in the state that would go to the Exchange. Could be for Exchange only or all policies sold.
Advertising	Allow private companies to advertise on Exchange Website for a fee.
Commercial Partnerships for Direct Marketing	Similar to advertising included in utility bills in some states, allow certain companies to send direct mail advertisements to Exchange enrollees.
Administrative Fees to the Reinsurance Entity	A fee on the federally mandated reinsurance program.

Industry-Wide Fee	A fee charged on all providers, health insurers, TPAs, and insurance agents in the state.
All Insurance Plans	An assessment on all insurance plans sold in the state on a covered lives basis

PCG analyzed each of these options with respect to the set of determining factors described below.

Potential Revenue

The potential revenue calculation varied widely based on the characteristics of the revenue stream. Broadly, however, these calculations utilized inputs such as Exchange enrollment projection, expected average premium post-reform, and several assumptions regarding market sustainability, pricing, and demand.

Operational Feasibility

The operational feasibility analysis accounts for the technology and administrative workflows required to implement each option and the alignment of any new processes with other Exchange functions or other current State processes. This analysis also includes a high level discussion of cash flows for each option and how the timing of cash flows may affect feasibility.

Potential Risks

The analysis of potential risks covers a range of risk areas, including political, financial, and market risks. Risk exposure is calculated for each option and each risk area by quantifying the following:

Probability: Assessment of likelihood that the risk will occur, rated on the following scale:

5	<i>Extremely likely occurrence</i>
4	<i>Probable occurrence</i>
3	<i>Possible occurrence</i>
2	<i>Unlikely occurrence</i>
1	<i>Highly improbable occurrence</i>

Impact: Estimate of the potential impact to the Exchange and the State following risk occurrence, rated on the following scale:

5	<i>Critical Impact</i>	Threatens the success of the Exchange and/or reputation of the State
4	<i>High Impact</i>	Causes significant disruption to the Exchange or the State
3	<i>Medium Impact</i>	Causes impacts to Exchange or State operations and financing
2	<i>Moderate Impact</i>	Disrupts Exchange or State processes with manageable impacts
1	<i>Marginal Impact</i>	Disrupts Exchange or State processes with negligible impacts

Level of Control: Indication of the level of control that can be exerted over the probability of risk occurrence, rated on the following scale:

5	<i>Total</i>
4	<i>Moderate</i>
3	<i>Shared</i>
2	<i>Minimal</i>
1	<i>No control</i>

Risk Exposure: Function of the above inputs to calculate risk severity:

$$\text{Risk Exposure} = \frac{\text{Probability} \times \text{Impact}}{\text{Level of Control}}$$

The above analyses, taken as a whole, directly informed the development of recommendations for the State of Alaska to pursue. The recommendations detailed in this report include a discussion of draft budget projections for the Exchange and how a break-even point may be successfully maintained.

6.2. Potential Revenue Summary Chart

The following chart demonstrates the potential revenue from the funding sources summarized above and discussed in more detail below.

Table 9: Potential Revenue Summary Chart

Funding Source	Potential Revenue
QHP Administrative Fees	\$90,000
Consumer Administrative Fees	\$6,153,840
Accreditation Fees to Agents and Brokers	\$6,480
Advertising	\$144,000
Commercial Partnerships for Direct Marketing	\$154,000
Administrative Fees to the Reinsurance Entity	\$39,120
Industry-Wide Fee	\$865,200
All Insurance Plans	\$2,931,066

6.3. Revenue Options Analysis

6.3.1. Qualified Health Plan Administrative Fees

There are two general manners in which an administrative fee could be levied on QHPs in the Exchange. In the first method included in this analysis, the Exchange charges a flat, monthly fee to each QHP for posting the product on the exchange, similar to the fee charged to sellers by online auction sites. In the second method, the exchange charges a fee that is equal to a percentage of the premiums collected. In theory, this method accounts for all ancillary benefits associated with using the Exchange, including access to an exclusive market (subsidy population), marketing, distribution, and other administrative activities.

Potential Revenue

For the first method, the revenue calculation assumes a monthly fee of \$100 per plan for posting the product to the exchange Website, and a total exchange market of 75 individual plans. The second method utilizes a projected exchange enrollment of 77,000 lives (the estimated enrollment from the actuarial report), with an average monthly premium of \$333 (the 2011 average individual market premium), and assumes an administrative fee of 2 percent of premiums collected. A 2 percent administrative fee equates to roughly \$6.70 per member per month.

Note that in the second method, the fee applies on a per capita basis. Thus coverage for families in Alaska, who will more likely qualify for exchange subsidies than individuals, will automatically incur a higher administrative fee than individual coverage.

Table 10: Potential QHP Administrative Revenue

Method	Base	Assumptions	Total Revenue
Flat Monthly Fee	12 months	<ul style="list-style-type: none"> • 75 plans • \$100 fee/month 	\$90,000
% of Premiums	<ul style="list-style-type: none"> • 12 months • 77,000 lives • \$333 monthly premium 	2% fee/month	\$6,153,840

Operational Feasibility

If the Exchange acts as a pass through for premium collection, then collecting a percent of premiums would simply require retaining a portion of premiums prior to remitting payments to the plans. If the exchange does not perform this function for the individual market, plans may be required to submit monthly payments to the exchange. When planning for accounts receivable and general accounting systems, the exchange would need to plan for this capacity and a potential delay in cash flows by 30 to 60 days.

Potential Risks

The risk profile for a QHP administrative fee is relatively low at 1.80. No political risks were included in this analysis as this option is considered well-aligned with private market objectives.

Table 11: Risks for QHP Administrative Fees

Risk Category	Description	Probability	Impact	Control	Exposure Rating
Political	N/A				
Financial	Revenue is entirely dependent on the number of enrollees and/or the number of plans that are posted to the exchange Website. If enrollment is too low or fewer plans are offered on the exchange than expected, fixed costs of the exchange may not be covered.	3	4	4	3
Market	If the fee is too high, QHPs may be discouraged from participating or offer fewer plan variations to avoid MLR implications.	3	4	5	2.4

6.3.2. Consumer Administrative Fees

Potential Revenue

The revenue calculation for this option is the same as the calculation of the percent of premium QHP administrative fee. In this scenario, however, the two percent fee is charged to exchange consumers and directly incorporated into the monthly plan premium. The total revenue again equals \$6,153,840, using the same base and assumptions as described previously.

Operational Feasibility

As in the QHP administrative fee, if the exchange acts as a pass through for premium collection, then collecting a percent of premiums would require retaining a portion of premiums prior to remitting payments to the plans. If the Exchange does not perform this function for the individual market, plans may be required to submit monthly payments to the exchange. When planning for accounts receivable and general accounting systems, the Exchange would need to plan for this capacity and a potential delay in cash flows by 30 to 60 days.

Potential Risks

The risk profile for the consumer fee is somewhat higher than that of the QHP fee due to the inclusion of potential political risk.

Table 12: Risks for Consumer Administrative Fees

Risk Category	Description	Probability	Impact	Control	Exposure Rating
Political	Given that many health care reform debates have focused on the burden of costs on the consumer, adding an additional cost on the consumer may be perceived as further bureaucracy, particularly to those who view the exchange as a tool for plans to sell products. This notion may lead to a lack of support and underutilization of the Exchange.	1	5	4	1.25
Financial	Revenue is entirely dependent on the number of enrollees that utilize the Exchange. If enrollment is lower than expected, fixed costs may not be covered.	3	4	4	3
Market	A consumer fee would automatically raise the price of Exchange plans by the total amount of the fee. If the fee is considered by the consumer to be too high, the individual may opt to purchase outside of the Exchange.	1	5	4	1.25

	Depending on other market factors, risk selection may result. Similarly, plans may perceive the addition of cost outside of their control as inhibitory to their pricing practices and opt not to participate.				
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6.3.3. Accreditation Fees to Agents and Brokers

Under this option agents or brokers who wish to be considered Exchange resources and receive referrals from Exchange consumer assistance programs would need to obtain accreditation from the Exchange, which would incur an administrative fee.

Potential Revenue

According to the National Association of Health Underwriters⁶, there were 108 certified member insurance agents and brokers operating in the State of Alaska in February 2012. The revenue calculation assumes that 80 percent of certified agents and brokers will seek accreditation from the Exchange, paying an annual administrative fee of \$75. Total revenue of \$6,480 can be expected under this scenario.

Operational Feasibility

Operationally, this option should be relatively simple to execute, as the fee would be processed like a transaction fee at point of accreditation. The relatively low number of expected transactions should not significantly impact technological capacity or other processes.

Potential Risks

As in the QHP fee analysis, no political risks were included in this analysis as this fee would likely be viewed as aligned with private market practices. However, there is a risk that brokers would object to paying the fee and less business would be steered to the Exchange.

Table 13: Risks for Agent and Broker Accreditation Fees

Risk Category	Description	Probability	Impact	Control	Exposure Rating
Political	N/A				
Financial	Revenue is entirely dependent on the willingness of agents and brokers to participate in the exchange. If they do not choose to gain accreditation	4	1	5	0.8

⁶ National Association of Health Underwriters Monthly Membership Report, February 2012. http://www.nahu.org/members/GAINReports/2012%20GAIN/0212_FinalReport.pdf

	through the exchange, revenue will be reduced accordingly.				
Market	An accreditation fee may discourage agents and brokers from supporting the exchange and spur a campaign to lead consumers to other purchasing channels.	4	3	5	2.4

6.3.4. Advertising

The Exchange Website would attract a large market of low to middle income consumers, as well as unemployed, underemployed, and self employed individuals. Companies offering products that are targeted to similar demographics may, therefore, choose to advertise on the Exchange Website if that option is available. Potential advertisers may include discount retailers, couponing sites, adult education and job training programs, credit counseling services, as well as community health and primary care providers.

Potential Revenue

The advertising revenue calculation is limited to the sale of banner advertisements on the exchange Website. The calculation assumes four high traffic pages (Home, Search, Compare, Enroll), two banner spaces per page (top header and right column “sky scraper”), five ad rotations per space per month, and a \$300 average flat fee per month. Under these assumptions, total annual revenue would equal \$144,000.

Operational Feasibility

Incorporation of ads into the Exchange Website should be a relatively easy process. However, ads will likely need to be approved by the State before posting, and will add an additional operational workflow, and thus additional administrative cost to maintain.

Note that there are many methods for pricing Web advertising. The most common are pay per click, pay per impression, or pay per lead. While these methods increase the advertiser’s confidence level that consumers are receiving the message, they do not provide a predictable level of revenue for the exchange or expense for the advertiser. Flat fee pricing is more popular when the demographics of Website visitors are known and the volume of traffic is predictable. Advertising on the Exchange may therefore become a more attractive option to potential advertisers after the Exchange has been operational for a longer period of time and traffic history can be analyzed.

Potential Risks

Risks associated with this option include those resulting from an unfavorable association of certain advertisers with the Exchange and the overall ability of the Exchange to sell the ad space.

Table 14: Risks for Advertising Revenue

Risk Category	Description	Probability	Impact	Control	Exposure Rating
Political	Companies that advertise on the Exchange will have an inherent association with the Exchange. If a company becomes the subject of controversy, the Exchange's reputation in the community may be damaged via that established association.	2	4	4	2
Financial	Revenue is dependent on the attractiveness of the Exchange to potential advertisers. If the Exchange cannot sell the space, revenue will decline accordingly.	3	2	3	2
Market	If advertising of certain products or services was perceived to directly or indirectly benefit certain insurance industry producers, alleged favoritism could cause stress on the insurance market and diminish health plan or broker participation in the Exchange.	1	3	5	0.6

6.3.5. Commercial Partnerships for Direct Marketing

Partnerships for direct marketing in this analysis focus on two methods: the inclusion of flyers in Exchange mailings, similar to the ads that are often included in utility bills, and the inclusion of an email signup option at the point of enrollment. The e-mail signup would allow Exchange enrollees to choose to receive e-mail offers, coupons, or promotions from a variety of Exchange “partners” or “sponsors” by clicking the associated button on the Exchange Website.

Potential Revenue

For the first method, the revenue calculation assumes an exchange enrollment of 77,000. This number somewhat inflates the calculation, however, as it does not account for the fact that multiple covered individuals may be living in the same household (as in family coverage). However, given the expectation that the bulk of the Exchange enrollment will come from the individual market, the figure is likely not overly inflated. The first method assumes a charge rate of \$0.50 per piece. Given the price of postage and potential market that will use these mailings, a \$0.50 unit price is highly competitive.

For the second method, an average cost per lead (CPL) rate of \$0.85 is based on a 2011 CPL Benchmark Study by industry conducted by Pontiflex.⁷ Rates comprising the average include those charged for consumer goods, nonprofits, health, and online retail when basic fields are obtained (name, e-mail, address).

Table 15: Potential Revenue for Commercial Partnership for Direct Marketing

Method	Base	Assumptions	Total Revenue
Direct Mailings	77,000 enrollees	<ul style="list-style-type: none"> • 2 mailings per year • 2 ads per mailing • \$0.50 charge per ad 	\$144,000
Email Signup	<ul style="list-style-type: none"> • 12 months • 77,000 lives 	<ul style="list-style-type: none"> • 5 buttons • 2 rotations per button • \$0.85 average CPL • 5% lead rate 	\$112,718

Operational Feasibility

Incorporation of ads into Exchange mailings should have very minimal impact on Exchange operations. Again, however, ads will likely need to be approved by the State before inclusion, which adds a workflow. E-mail signups should require similarly small operational and technical requirements as the use of banner advertisements.

Potential Risks

The risks associated with this form of marketing are very similar to those associated with banner advertisements. However, the impact of the political risk is heightened due to the perceived closer connection of partners to the Exchange.

Table 16: Risks for Commercial Partnership for Direct Marketing

Risk Category	Description	Probability	Impact	Control	Exposure Rating
Political	Companies that advertise on the Exchange will have an inherent association with the Exchange, and those that reach consumers through Exchange partnerships may have an even stronger association. If a company becomes the subject of	2	5	4	2.5

⁷ Pontiflex CPL Benchmark Study, 2011 <http://www.onlinemarketing-trends.com/2011/03/cost-per-lead-by-industry.html>

	controversy, the Exchange's reputation in the community may be damaged via that established association.				
Financial	Revenue is dependent on the attractiveness of the Exchange to potential advertisers. If the Exchange cannot sell to advertisers, revenue will decline accordingly.	3	2	3	2
Market	There is a risk that advertising in this manner could deter or overwhelm consumers during the enrollment process and cause them to choose other channel in future.	1	4	4	1

6.3.6. Administrative Fees to the Reinsurance Entity

Under current federal guidance, a reinsurance entity must operate for the first three years of Exchange operations in order to account for the coverage of high risk individuals under the new required rating rules. All plans and third party administrators in each state will be required to remit a nationally established per capita contribution to the reinsurance entity. The reinsurance entity will then make payments to individual insurance plans covering the highest risk individuals in the state. Federal regulation provides the option for states to collect an administrative fee to support reinsurance entity operations in addition to per capita contributions.

Potential Revenue

The revenue calculation is based on a 489,000 expected number of privately insured post-2014 from the actuarial report. The calculation assumes a quarterly remittance and an administrative fee of \$0.02 per capita. Total revenue under this scenario equals \$39,120.

Operational Feasibility

Administering this fee would require the reinsurance entity to retain and account for a portion of collected contributions to reimburse administrative expense. Operational impact should be marginal.

Potential Risks

Political and financial risks were not included in this analysis as the collection of revenue will be directly tied to a required national fee, and the administrative fee portion is a dollar value rate. Thus no significant variation in cash flows is expected.

Table 17: Potential Risks for Reinsurance Entity Administrative Fees

Risk Category	Description	Probability	Impact	Control	Exposure Rating
Political	N/A				
Financial	N/A				
Market	Payments are statutorily mandated, however, the addition of an administrative fee is not. Imposing such a fee could make Alaska appear less competitive to insurers and TPAs.	1	4	5	0.8

6.3.7. Industry Wide Assessment

An industry wide assessment would levy a fee on all health care industry members, including providers. The theory behind this option is that all factions of the health care community would benefit, either directly or indirectly from a successful exchange. Providers, for example, may realize higher revenue as insurance coverage increases and uncompensated care declines. Insurance carriers outside of the Exchange may benefit from a greater comfort level and understanding among individual consumers in shopping for insurance and the overall expansion of insurance coverage.

Potential Revenue

The revenue calculation for this option includes a number of broad assumptions as there are many unknowns regarding how such a fee would be structured. According to the DHSS, there are 11 general acute care hospitals, 1 LTC Acute Care Hospital, 2 Rural Primary Care Hospitals, 2 Critical Access Hospitals, 2 Specialized Hospitals, 7 Alaska Native Tribal Hospitals, 15 Nursing Facilities, 3 Full Service Hospice Centers, 14 Home Health Agencies, 2 Rural Health Clinics, 2 Frontier Extended Stay Clinics, 8 Birthing Centers, 13 Ambulatory Surgical Centers, 7 End Stage Renal Disease Centers, and 11 Outpatient Physical Therapy/Speech Pathology Centers licensed in the State. The calculation additionally includes the 9 health insurance carriers with more than 1 percent of market share in at least one market, and 108 NAHU registered agents and brokers.

In the absence of data regarding individual carrier and provider capacity, an average monthly fee of \$350 per entity was used to estimate the dollar value revenue of \$865,200.

Operational Feasibility

This type of fee would likely have to be paid through a state tax system as the Exchange would not be providing a direct service or direct access to all entities assessed, and thus would not have access to or control over any additional monetary transaction. The Exchange would need to coordinate efforts with other state departments in order to receive funds in a timely manner.

Potential Risks

The largest risk associated with this option is that it appears to tax an entire industry in support of a program that may only indirectly benefit some industry members.

Table 18: Potential Risks for Industry Wide Assessment

Risk Category	Description	Probability	Impact	Control	Exposure Rating
Political	This option may be viewed as a State-wide tax and attract political criticism.	5	4	3	6.67
Financial	Due to the tenuous nature of the connection between some industry members and Exchange benefits, costing this fee appropriately would prove difficult. Depending on how it is structured, Exchange revenue may be contingent on reported revenue or other factors self reported by providers, insurers, brokers, etc. If underreported or actual numbers are less than expected, this option could lead to financial shortfalls for the Exchange.	2	4	4	2
Market	Providers will be critical to effective outreach and education. This type of fee may alienate this sector of the market and lead consumers to other channels.	2	4	3	2.67

6.3.8. Insurance Plan Market Wide Assessment

The market-wide assessment charges a fee to all insurance plans offered in the State to support exchange operations. Similar to the above industry-wide option, the market-wide assessment assumes that all insurance carriers will benefit from the establishment of the Exchange as it creates market efficiencies and attracts and educates consumers about the importance of health insurance coverage.

Potential Revenue

The revenue calculation for this option assumes a fee assessed on a per capita basis on all insurance plans. The expected total private coverage enrollment of 489,000 constitutes the base of the calculation. The calculation assumes a \$0.50 fee per member per month, which equates to approximately 0.15 percent of the 2011 individual market premium. Under this scenario, total revenue equals \$2,931,066.

Operational Feasibility

An assessment on all insurance plans offered in the State would typically be administered as a state tax. Coordination of efforts in collecting fees in a timely manner would be required.

Potential Risks

Financial risk associated with this option is substantially lower than fees levied on QHPs as the fee is a dollar value assessed on a per capita basis. Therefore the additional unknowns associated with consumer behavior in using the exchange and the value of total premiums is eliminated.

Table 19: Potential Risks for Insurance Plan Market Wide Assessment

Risk Category	Description	Probability	Impact	Control	Exposure Rating
Political	Similar to the industry assessment, this option may be viewed as another state tax, and thus erode political support for the Exchange. However, the probability of this occurrence is somewhat lower do the more limited nature of this assessment.	3	3	4	2.25
Financial	If total enrollment in health coverage is substantially less than expected post 2014, financing through this option may fall short.	1	3	4	0.75
Market	The inclusion of a fee on all plans could make the Alaska market less attractive to insurance carriers.	2	5	4	2.5

6.4. Recommendations

The model Exchange costs shows a modeled cost of \$6,772,299.98 for Exchange functions. No single potential revenue source outlined above equals this amount, but the consumer administrative fee does approach this amount with an estimated revenue stream of \$6,153,840 per year. The difference could be made up with advertising revenue or general fund revenue. A cost on users of the Exchange may make the most sense, because only those who use the Exchange would be required to help fund it.

On the other hand, there may be a desire to spread the costs of operating the Exchange to as broad of a base as possible. This would have the benefit of sharing the burden of the Exchange to all of those who benefit both directly and indirectly, from its existence. An all insurance carrier fee or an industry wide fee would accomplish this goal.

Finally, though the potential revenue is not outlined here because it is too difficult to predict the political will and potential revenue, the State of Alaska may want to explore using general fund revenues to help pay for Exchange operations. General funds would not have to be used to pay for the entire cost of the Exchange, but could instead supplement any combination of the outlined revenue options in order to meet the full cost of the Exchange. General fund revenues could be combined with an Exchange user fee to lower the fee to Exchange users (which would help to keep Exchange insurance costs equal to those of the



market outside the Exchange) to fully fund the Exchange while spreading its costs the Exchange to as broad of a base as possible.

Future year cash flows into the years 2016, 2017 and beyond will be largely dependent on Exchange enrollment, staffing decisions made by the State, and also the technology solutions the Exchange ends up being based on. However, there are an array of options that, when combined, should allow the Exchange to be fully sustainable in the future.

7. FINANCIAL ANALYSIS

7.1. Introduction

This section of the report presents the results of the review and assessment of the expected costs of a state operated Exchange. The costs are shown using the estimated Exchange enrollment of 77,000 (both individual and SHOP Exchanges) from the actuarial report created for the State of Alaska as part of this engagement. The figure of 77,000 is used to create a baseline Exchange cost model. Since it is impossible to be fully confident regarding the eventual enrollment in the Exchange, cost sensitivity analysis was performed estimated enrollment up and down 50 percent in order to provide a range of expected costs. In order to model the costs of different enrollment figures, fixed and variable costs were identified. The methodology of this is explained in more detail later in the report.

The detailed modeling focuses on a state-based Exchange. Costs of exchange models that have federal involvement (either a fully run federal exchange or partnership model) have not yet been provided by the federal government. The federal government has not yet built its information technology infrastructure for the FFE. It is unclear how much it will ultimately cost the federal government to run its side of exchange operations, how many states will participate in federal models, and how costs will be allocated to participating states. The costs of a federally facilitated exchange will likely differ across states, as the federal system will have to interact with differing state systems. In addition, costs of the federal exchange will be different if a state chooses to utilize a partnership model. However, there has not yet been detailed guidance from the federal government on how it plans to organize this process.

One known fact is that the FEE will be funded by user fees collected from participating issuers. However, the exact nature and amount of that fee has not been released.

While it is unclear how much any federal model would cost participating Alaskans, there will definitely be a cost associated to the participating citizens for a federal exchange.

7.2. Necessary Exchange Functions and Budget Estimates

This section of the report provides a high-level description of the staffing, capabilities, and costs associated with operating a State-run Exchange in Alaska. The description includes the resources needed to perform requirements laid out in guidance from HHS, CCIIO, and subsequent rules (published in the Federal Register on 3/27/12). PCG has included reasonable assumptions based on professional judgment, comparable data from the State of Alaska (where available), experience with other organizations that perform similar functions, and analysis of other publicly available data and reports.

Notwithstanding this effort, there are functions required of the Exchange for which there is no comparable experience on which to rely. In these cases, PCG has attempted to estimate the workload, qualifications of the staff, intensity of the work, and other factors that drive staffing and expenses.

The Exchange must carry out several functions required by the ACA. Each of the minimum functions of the Exchange are listed below and set forth in Sections 1311(d)(4), 1341, 1343, and 1411-1413 of the ACA.

- Certification, recertification, and decertification of qualified health plans;
- Call center;
- Exchange Website;
- Premium tax credit and cost-sharing reduction calculator;
- Quality rating system;
- Navigator program;
- Eligibility determinations for Exchange participation, advance payment of premium tax credits, cost-sharing reductions, and Medicaid;
- Seamless eligibility and enrollment process with Medicaid and other State health subsidy programs;
- Enrollment process;
- Applications and notices;
- Individual responsibility determinations;
- Administration of premium tax credits and cost-sharing reductions;
- Adjudication of appeals of eligibility determinations;
- Notification and appeals of employer liability;
- Information reporting to IRS and enrollees;
- Outreach and education;
- Risk adjustment and transitional reinsurance; and
- SHOP Exchange-specific functions.

The estimates developed in this report address these CCIIO requirements and the business functions necessary to implement an Exchange. If the actual approach employed by the State varies from the assumptions made in this report, or if the State's final approach involves additional functions not contemplated here, then the estimates contained in this analysis (e.g. the staffing requirements and other expenses) could vary from actual results.

High level assumptions include:

- Determination of administrative requirements of the Exchange based on the CCIIO guidance regarding required functions outlined in the January 20, 2011 application and subsequent rule making;
- Development of an assumed organizational structure and approach for performing the required functions;

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- Identification of appropriate positions and job responsibilities necessary to carry out the work;
 - Estimation of the number of FTEs for each position based on ratios, volumes, and professional judgment;
 - Determination of reasonable salaries for each position based on comparable positions in Alaska using the 2009 Salary Survey Report created by Fox Lawson & Associates found at <http://doa.alaska.gov/dop/fileadmin/SalarySurvey/FullReport.pdf>;
 - Ongoing costs of operating the Exchange with other funding sources (either federal or state) until 2014;
 - Addition of payroll taxes and benefits at a fringe benefit rate of 32 percent;
 - Addition of other direct costs derived using several different methodologies such as per member per month(PMPM) factors, estimated cost per FTE, or line item estimates;
 - Eligibility and Enrollment cost estimate based on professional experience in other states;
 - Call center estimates based on information from a call center in Maine and publicly available documents estimating the needs of a call center for North Carolina's future Exchange were analyzed. In addition, a call center calculation was applied; and
 - Utilization of existing similar entities including budget estimates from the Utah Health Exchange, the Massachusetts Connector FY 2010 budget, projections for North Carolina and Delaware, and professional judgment to estimate other Exchange business functions that include premium billing, marketing, navigators, Website and it systems, and general administrative cost.

Finally, it is important to remember that the enrollment estimate of 77,000 used for scaling costs in this cost model is predictive in nature and should be expected to differ from actual Exchange enrollment in 2014 and beyond.

7.2.1. Full Time Employee Salary and Benefits

The Exchange will require a core group with executive level authority to operate the Exchange.

It is envisioned that the Exchange will be led by an executive leadership team comprised of top executives responsible for each of the major functional areas (operations, marketing, information systems, and finance). One Executive Director would act as the main authority figure, overseeing all decisions made by the agency. This position would oversee all Exchange operations, including:

- Operations: Directed by the Executive Director, this unit will be responsible for the overall operation of the Exchange. Exchange staff will be responsible for human resources, payroll, procurement, legal services, and contract management. For the purposes of this analysis, it is assumed that Alaska will leverage purchased services for eligibility and enrollment, premium billing, and plan administration and reporting.
- Information Technology: Directed by the CIO, the Information Technology unit will manage the IT support structure of the exchange. This includes managing contracts with Website design and hosting firms and managing the overall systems of the Exchange.

- **Finance:** Directed by the Executive Director, this unit will manage all accounting, accounts receivable/accounts payable, financial reporting, analysts, and specialty contractors. These individuals will include actuaries, CPAs, and other financial consultants as necessary.

The estimated staff of the Exchange was created based on conversations with State staff, PCG's professional experience in the field, and a review of existing and planned Exchanges. Beyond receiving input from State staff, PCG's review included an analysis of existing Exchanges' operating budgets, Exchanges that are moving forward with their planning process (Colorado, Delaware, and others) and materials from research and reports for various peer states. An organizational structure was designed that identified 5.1 positions. It is assumed that some staff members can be shared with existing state resources (e.g. legal staff from the attorney general's office and some administrative staff).

Salaries are benchmarked to comparable positions in using the 2009 Salary Survey Report created by Fox Lawson & Associates found at <http://doa.alaska.gov/dop/fileadmin/SalarySurvey/FullReport.pdf>. For the fringe benefit calculation, PCG utilized a rate of 32 percent, which is an accepted fringe rate across the nation and has been used in other modeling exercises.

The following chart shows the cost estimate of the salary and benefits of the Exchange for these 5.1 FTEs.

Table 20: Estimate of Salary and Benefits for Exchange Staff

Position	Responsibilities	AK Comparable Position	FTEs	AK Benchmark Salary	Exchange Salary Liability	Fringe (32%)	Total
Executive Director	Overall management and strategy of the organization.	Division Director – PX	1	\$92,796	\$92,796	\$29,695	\$122,491
CIO	Information systems director.	Systems Programmer II	1	\$68,256	\$68,256	\$21,842	\$90,098
Administrative Assistant	Assist executives.	Administrative Clerk 2	1	\$27,324	\$27,324	\$8,744	\$36,068
Financial and Accounting Analyst	Provide data analyses, manage Exchange AP/AR, and other financial tasks.	Accounting Technician I	0.5	\$34,704	\$17,352	\$5,553	\$22,905
Human Resources	Hiring, benefit design, and other HR functions.	Human Resource Specialist I	0.25	\$45,924	\$11,481	\$3,674	\$15,155
QHP and Benefit Manager	Monitors benefits plans, completes federal reporting, processes	Human Resource Technician II	0.25	\$39,996	\$9,999	\$3,200	\$13,199

	payroll.						
General Counsel	Provides legal support services.	Attorney II	0.1	\$114,108	\$11,411	\$3,651	\$15,062
Contracting / Procurement Agent	Procurement Specialist III	Purchasing Manager	1	\$52,176	\$52,176	\$16,696	\$68,872
Total			5.1	\$475,284	\$290,795	\$93,055	\$383,850

7.2.2. Enrollment and Eligibility System

Section 1311, 1411, and 1413 of the ACA identify many of the Exchange functions associated with enrollment and eligibility systems. This legislation and subsequent rules and guidance has articulated a broad vision of what an exchange must do, how it must operate, and the desired outcomes from its establishment in each state. The ACA requires online, real time verification of application information to occur at the federal level through a series of interrelated data matching protocols developed by the Secretary of HHS in conjunction with Homeland Security, Social Security Administration, and the Internal Revenue Service. At the most basic level, the Exchange must verify that the applicant is qualified to purchase insurance through the Exchange. For this the cost is limited to the automated infrastructure. However for individuals applying for a premium subsidy, Medicaid, or CHIP the application process can be very complex.

The State of Alaska has to decide on how eligibility for the Exchange, Medicaid, and CHIP will be streamlined and integrated as well as the degree to which existing IT systems need to be integrated into the overall solution. The four primary options to address eligibility are as follows:

1. Modify existing systems to perform eligibility determinations on behalf of the Exchange;
2. Implement a separate rules engine to perform eligibility determinations on behalf of the Exchange;
3. Build a new eligibility system or replace existing eligibility system; or
4. Do nothing and rely on the Federal Exchange to perform determinations for the Exchange.

Each of the options above have positive and negative implications for the State in terms of the level of resources required, time to implement, likelihood of achieving compliance, and overall costs. In Alaska's case, the State has already taken some steps to address this key area of need for the Exchange through its analysis of the costs of a new eligibility system to replace the State's current EIS. Alaska staff have reported that it is hoped that any replacement system for EIS will be able to interact with the Exchange, however, such functionality was not included in the research already conducted for a new EIS system. For this reason, higher than average costs for the eligibility system are assumed in this report. Before specific estimates for the State of Alaska are made, it is instructed to consider the costs of the four options outlined above.

The table below summarizes the cost estimate ranges for each of the aforementioned options. These estimates are intended to be inclusive of all components including state personnel, contractor expenses, consulting services, software, and hardware for the entire lifecycle of the project. Ongoing Maintenance and Operations costs are estimated on an annual basis. These cost estimates have been developed from a range of sources from PCG's research and experience and also take into account information supplied by the State of Alaska.

In particular these estimates rest on the following key assumptions and constraints:

- Any selected option will require State personnel time and modifications to existing systems at a minimum.
- Estimated ranges are listed to account for variations in the solutions design and scope – ultimate cost will vary depending on final scope.
- These estimates do not take into account the availability of federal matching funds in order to demonstrate the full costs of the system. In addition, the costs in the chart do not break out the cost to the Exchange itself verses the total costs of the system.

Table 21: Estimate for Enrollment and Eligibility System Options

Description	One-Time Design, Development, and Implementation	Ongoing Maintenance and Operations
Option 1: Integrate changes into existing Eligibility Environment.	\$4-6M	\$600-900k
Option 2: Develop the Phased Integration with an Eligibility Engine solution to process eligibility determinations. (Use existing infrastructure.)	\$10-20M	\$1-3M
Option 3: Replace the entire eligibility system	\$35-70M	\$5-10M
Option 4: Do nothing and utilize the Federal Solution	\$1.5M - \$3M	\$600-900k

As illustrated above, there are wide variations in the potential costs depending on the direction the State takes to address the needs of the Exchange. Option 4 represents the least potentially expensive option because it does not require much systems development work, only integration of the Federal Solution into Alaska's existing environment, but it is also the option with the most uncertainty since the specifications of the Federal Exchange are not known at this time. Additionally, State staff indicate a strong desire for the State of Alaska to find a State specific solution for Exchange creation and a preference to not rely on federal solutions. For this reason, the cost estimate of the eligibility system rule out a federal option.

Option 1, the next least expensive option, does not seem to be a feasible option given the State's determination that its existing systems do not meet the future needs of Medicaid, CHIP, and other eligibility determination functions currently performed by EIS.

Options 2 and 3 represent the most expensive options in that they both involve development of new IT systems and platforms for eligibility. While the potential costs are much higher, both of these options are more likely to satisfy the federal guidance and standards for a modern, scalable, flexible and interoperable eligibility system. As a result, they also have the highest probability for the State of Alaska to take full advantage of unique federal reimbursement opportunities for eligibility systems if the State chooses to utilize such funds. As mentioned above, the State of Alaska has stated a preference to develop a new eligibility system for Medicaid and CHIP as a result of its findings that EIS unlikely to adequately support new Medicaid eligibility standards (using MAGI) and future business needs. However, it should be noted that a complete systems replacement, while deemed necessary by state experts, is a significant and time consuming endeavor and there is a high likelihood that it cannot be completed in the restrictive timeframes imposed by the ACA. Furthermore, PCG's analysis indicates a potentially much higher overall cost for a system replacement than the current estimates provided by the State.

As a result of these realities, a more phased approach to system replacement, utilizing a new eligibility rules engine for the immediate needs of the Exchange and meeting ACA mandates, and building a platform for additional enhancements for other aspects of eligibility, is perhaps a more attractive option. This approach is also one that many other states are currently contemplating who are in a similar position to the State of Alaska – relying on older, inflexible technology platforms and actively looking to transition to a new platform that is better suited for the current business needs.

The State of Alaska's current preference according to State staff is pursue Option 3. Given that the current EIS system is in its third decade and unable to handle new standards as well as Exchange operations, PCG has determined that it is reasonable to assume that Option 3, while a high cost option, is a reasonable expectation of what path the State will have to take.

For the purposes of this cost model, start-up costs are not included in the 2014 cost to the Exchange, since they will not be the burden of the Exchange in terms of financial sustainability in future years (and could possibly be paid for using federal funds). In addition, for the Exchange cost model, PCG has broken out the costs the Exchange must pay from the cost of the complete system's Maintenance and Operation (M&O) cost as a function of anticipated enrollment in the Exchange as compared to Medicaid enrollment predicted by the actuarial report in 2014 (77,000 in Exchange and 123,000 in Medicaid). The upper yearly baseline estimate M&O cost of \$10,000,000 is assumed after discussions with State staff on their assumed costs of a new EIS system. Applying the ratio of Exchange cost to this figure creates an ongoing estimate of \$3,850,000 for the Exchange.

7.2.3. Call Center

The ACA mandates that the Exchange have an operational call center that can guide consumers through the process of purchasing care via the Exchange and also answer questions from individuals or businesses. Staff and costs requirements for the call center will be largely dependent on call volume, but

there will also be a subset of fixed costs (e.g. management, rent, and equipment) that must be borne in times of very few calls just as in time of heavy call volume.

The cost of the call center will depend on staffing requirements, which in turn are very sensitive to call volume and call length, as well as the amount of time deemed acceptable for people to be on hold.

In order to estimate the potential cost of the Alaska call center, information from a call center in Maine and publicly available documents estimating the needs of a call center for North Carolina's future Exchange were analyzed. This information provided benchmark data for use in understanding potential call volume of Alaska's Exchange.

The following chart demonstrates the key variable factors for each call center:

Table 22: Call Center Variable Factors

Description	NC Estimate	Maine Data	Alaska Estimate
Estimated Population	795,791	306,280	77,000
Estimated % Contact	25%	50%	25%
# of Contacts	198,948	153,140	19,250
# FTEs	30	30	2
Total Cost	\$ 1,287,446	\$ 1,227,189	\$102,279

It is important to remember that the ultimate needs of the Exchange call center will be highly sensitive to call volume, duration and service level. PCG developed this estimate based on the relationship of FTE's, # of contacts, and cost. Alternatively, PCG verified the FTE estimate by analyzing it against a call center calculation. An Exchange population of 77,000 and a contact percentage of 25 percent would mean the Exchange would receive roughly 74 calls per day, or 7 in an hour if the call center operates for ten hours a day (8am – 6pm). Applying Little's Law, which is a restatement of the Erlang Formula, shows that mathematically there should be no more than one to two calls occurring at any given time (assuming a call time of eight minutes and a wrap up time of two minutes). Even when variability is taken into account, a total of two staff members should be able to handle total call volume each day. Salaries (including fringe) assume one Administrative Clerk II (\$36,068) and one human resource manager (\$66,211).

Given how few employees are required, it is assumed that they could be housed somewhere in existing state infrastructure and ancillary costs will be nominal. This creates a total call center cost estimate of \$102,279.

7.2.4. Premium Billing and Website

Rules from HHS released in proposed form July 11, 2011 and largely finalized in the Federal Register on March 27, 2012 clarified that SHOP Exchanges must bill and collect premiums from participating employers.

The premium billing “engine” is the IT component of premium billing, and the following cost estimate assume the state creates an automated solution to calculate premiums produce invoices and track payments. These estimates are derived from analyzing existing state systems that perform similar functions in other states, and professional judgment based on experience performing similar analysis in other states.

The federal government is willing to provide 100 percent funding for the start-up costs of this function through the establishment grant process, though it is unclear if the State of Alaska will utilize this option. However, this cost model is built to create a final figure for expected Exchange costs that must be met once the Exchange is fully operational, thus only ongoing maintenance costs are included in the final cost estimate (starting in 2014) as they will be the only costs the Exchange faces for its financial sustainability. However, for information purposes, since it is unclear what path the State of Alaska will take in building a system, total cost estimates for the engine are also provided below (though not included in the cost model itself).

The Exchange’s Website is one of the most important and more expensive IT-related facets of an Exchange. The Web portal will likely serve as the primary point of contact for consumers and employers to access information and conduct business with the Exchange as well as the central hub through which other IT systems and functions are accessed. Based on federal specifications and guidance, the portal must allow consumers the ability to determine their eligibility for health insurance assistance programs, compare options and enroll in the coverage of their choosing. The portal may also be designed for other online services for consumers, employers, and insurance carriers and as such, it may require integration with a variety of other IT systems. These and other design elements of the portal will have an impact on its overall development costs. Also, the portal’s central position in the Exchange environment will more than likely lead to higher ongoing operations and maintenance costs relative to other Exchange IT solutions.

The following table summarizes the expected costs of these functions. For the purposes of the cost model, middle range estimates for the ongoing maintenance cost were chosen. This provides a cost of \$650,000 for the Web Portal and \$225,000 for the Premium Billing Engine.

Table 23: Estimate of Exchange Web Portal Costs

Exchange IT Component	One-Time Design, Development and Implementation	Ongoing Operations and Maintenance
Web Portal	\$1-3M	\$300k-\$1M
Premium Billing Engine	\$1-2M	\$150-300k

7.2.5. Other Contracted/Consulting Services

It is expected that the Exchange will also contract other significant business functions. The descriptions below identify likely areas where consulting services will be used, outline the operations, and provide the methodology for the cost estimate.

Marketing

The Exchange needs to develop a comprehensive marketing plan that identifies outreach strategies to encourage individuals to apply for the individual and small group products. A direct market effort will educate the consumer on the new requirements, protections, and choices available. The execution strategy may include a media campaign and other traditional marketing activities as well as a community outreach campaign. The expense estimate is based on typical health plan advertising. The Exchange will be free to market as much or as little as it chooses, and may rely on general public knowledge of the law and individual mandate more than its own marketing effort. However, for budgeting purposes, some marketing costs should be and are assumed.

Navigator Program

Per the ACA, the Exchange must have a Navigator program that assists with outreach and enrollment functions. The population targeted by the Navigators may include individuals without Web-access, literacy, or insurance knowledge. The Navigator Program involves leveraging community resources to make information about the Exchange available to potential consumers via existing channels such as community organizations, brokers, and State agencies. Navigators must be trained and registered and this service will be provided at the expense of the Exchange. Navigators will conduct public education activities, distribute information about enrollment and premium credits, and provide enrollment assistance. An estimate of cost for Alaska can be established by using industry estimates in other states, which have largely been based on the Massachusetts Connector's per-enrollee budget for "outreach" which is the only identified like data point found to date. Alaska may also want to consider the associated costs with field representatives who worked to advertise the state's Denali KidCare program when it was first created.

Actuarial Analysis

The Exchange will require actuarial services as part of the plan qualification process and the risk adjustment process. The role of actuarial services would be significantly greater if the Exchange is designed as an active or selective purchaser, negotiating premiums with insurers offering plans through the Exchange. Furthermore, it is anticipated that certain actuarial studies, such as adverse selection monitoring and comparisons of the market inside and outside the Exchange, will be necessary.

Auditing

The Exchange will be required to submit Audited Financial Statements prepared according to standards applicable to the financial audits contained in Government Accounting Standards, issued by the Comptroller General of the United States. They require that a CPA plan and perform an audit to obtain

reasonable assurances that statements are free of material misstatement. The audit will consider internal controls, accounting principles, disclosures, and overall financial presentation. On an annual basis the Exchange would need to contract for a Financial Statement and Independent Auditors Report with a third party CPA firm.

Legal and Other Professional Consulting

The Exchange will likely face complex policy and regulatory problems that will require the assistance of a subject matter expert. This work could include government consulting services, regulatory advice and counsel, or public policy services.

7.2.6. General Administrative Costs

The Exchange will face a number of general administrative costs, possibly including rent, supplies, utilities and other sundry items. No cost was established for facility cost (plan operations, maintenance, security) and depreciation as it is assumed the Exchange will utilize existing office space. Supplies are cost at a percentage of total Exchange costs. Assumptions for the costs are based on professional judgment and research into State costs.

The following chart shows the estimated costs.

Table 24: Estimate of General Administrative Costs

General & Administrative	Assumptions	Exchange Cost
Facility Cost	The Exchange will be housed in existing state office space.	\$0.00
Supplies	Estimated based on a percentage of overall Exchange cost	\$33,986.75
Total		\$33,986.75

7.2.7. Summary of Alaska Exchange Cost at 77,000 Enrollment Estimate

Table 25: Summary of Exchange Cost at 77,000 Enrollment

Description	CY 2014
Salary and Benefits	
Executive Director	\$122,490.72
CIO	\$90,097.92
Administrative Assistant	\$36,067.68
Financial and Accounting Analyst	\$22,904.64
Human Resources	\$15,154.92
QHP and Benefit Manager	\$13,198.68
General Counsel	\$15,062.26
Contracting / Procurement Agent	\$68,872.32
Subtotal	\$383,849.14
Contract	
Eligibility and Enrollment System	\$3,850,000.00
Call Center	\$102,278.88
Premium Billing Engine	\$225,000.00
Marketing	\$644,329.90
Navigator	\$201,570.75
Actuarial	\$233,020.30
Auditing	\$36,685.54
Legal and Other Professional Consulting Services	\$411,578.72
IT and Website Design	\$650,000.00
Subtotal	\$6,354,464.09
Other Direct Expense	
Facility Cost (Plan Operation, Maintenance, Security)	\$0.00
Supplies	\$33,986.75
Subtotal	\$33,986.75
TOTAL	\$6,772,299.98
Estimated Exchange Population	77,000
Potential PMPM for Exchange Customers	\$7.33

7.2.8. Analysis of Exchange Costs Showing Enrollment at Differing Enrollment Totals

The estimate of 77,000 total enrollees in the Exchange is based on actuarial analysis of the Alaska marketplace. However, it is impossible to be sure how many people will actually enroll in the Exchange, and thus it is instructive and important to consider total Exchange costs based on different enrollment predictions. Sensitive analysis is thus performed at two additional enrollment figures. First, the cost of an Exchange with 115,500 enrollees is shown (150 percent of 77,000) and then the cost of the Exchange with 38,500 enrollees is demonstrated (50 percent of 77,000). The methodology for how the cost of an Exchange with these enrollment totals is described below.

7.2.8.1 Average Costs

PCG developed a process to allocate the cost components of the Exchange between fixed and variable cost. By analyzing the components of each of the cost categories and applying its professional judgment and past experiences, PCG produced a percentage of fixed and variable cost. The table below illustrates this allocation.

Table 26: Fixed vs. Variable Cost Allocations

Description of Contractor	% Fixed Cost	% Variable Cost
Salaries and Benefits	100%	0%
Eligibility and Enrollment	50%	50%
Call Center	25%	75%
Premium Billing Engine	75%	25%
Marketing	100%	0%
Navigator	100%	0%
Actuarial	100%	0%
Auditing	75%	25%
Other Professional Consulting	25%	75%
IT and Web Design	75%	25%
Facility Cost (Plant, Maint., Security)	75%	25%
Depreciation	75%	25%
Supplies	75%	25%
Other Expense	75%	25%

Note: Facility costs and associated depreciation are assumed at zero in this cost model, but calculated fixed and variable costs are still demonstrated for instructional purposes should be assumption prove erroneous.

Fixed cost was defined first based on 100 percent, 75 percent, 50 percent, and 25 percent. The variable cost was then determined as a function of the fixed cost minus the total cost to develop an annual unit cost multiplier. The unit cost multiplier was based on the original cost model enrollment figure of 77,000 for each category. This unit cost multiplier will be used to define the variable cost for changing enrollment.

Table 27: Exchange Costs with 38,500 Enrollees

Description	Fixed Cost	Unit Cost Multiplier	Enrollment	Variable Cost	Total
Salary and Benefits					
Executive Director	\$122,490.72	N/A	38,500	N/A	\$122,490.72
CIO	\$90,097.92	N/A	38,500	N/A	\$90,097.92
Administrative Assistant	\$36,067.68	N/A	38,500	N/A	\$36,067.68
Financial and Accounting Analyst	\$22,904.64	N/A	38,500	N/A	\$22,904.64
Human Resources	\$15,154.92	N/A	38,500	N/A	\$15,154.92
QHP and Benefit Manager	\$13,198.68	N/A	38,500	N/A	\$13,198.68
General Counsel	\$15,062.26	N/A	38,500	N/A	\$15,062.26
Contracting / Procurement Agent	\$68,872.32	N/A	38,500	N/A	\$68,872.32
Subtotal	\$383,849.14				\$383,849.14
Contract					
Eligibility and Enrollment System	\$2,887,500.00	\$12.50	38,500	\$481,250.00	\$3,368,750.00
Call Center	\$25,569.72	\$1.00	38,500	\$38,354.58	\$63,924.30
Premium Billing Engine	\$112,500.00	\$1.46	38,500	\$56,250.00	\$168,750.00
Marketing	\$644,329.90	\$0.00	38,500	\$0.00	\$644,329.90
Navigator	\$201,570.75	\$0.00	38,500	\$0.00	\$201,570.75
Actuarial	\$233,020.30	\$0.00	38,500	\$0.00	\$233,020.30
Auditing	\$27,514.16	\$0.12	38,500	\$4,585.69	\$32,099.85
Legal and Other Prof. Consulting Services	\$102,894.68	\$4.01	38,500	\$154,342.02	\$257,236.70
IT and Website Design	\$487,500.00	\$2.11	38,500	\$81,250.00	\$568,750.00
Subtotal	\$4,722,399.51			\$816,032.29	\$5,538,431.80
Other Direct Expense					
Facility Cost (Plan Oper., Maint., Security)	\$0.00	\$0.00	38,500	\$0.00	\$0.00
Supplies	\$25,490.06	\$0.11	38,500	\$4,248.34	\$29,738.41
Subtotal	\$25,490.06			\$4,248.34	\$29,738.41
Total	\$5,131,738.71			\$820,280.64	\$5,952,019.34
				Estimated HBE Population	38,500
				PMPM for HBE Customers	\$12.88

Table 28: Exchange Costs with 115,500 Enrollees

Description	Fixed Cost	Unit Cost Multiplier	Enrollment	Variable Cost	Total
Salary and Benefits					
Executive Director	\$122,490.72	N/A	115,500	N/A	\$122,490.72
CIO	\$90,097.92	N/A	115,500	N/A	\$90,097.92
Administrative Assistant	\$36,067.68	N/A	115,500	N/A	\$36,067.68
Financial and Accounting Analyst	\$22,904.64	N/A	115,500	N/A	\$22,904.64
Human Resources	\$15,154.92	N/A	115,500	N/A	\$15,154.92
QHP and Benefit Manager	\$13,198.68	N/A	115,500	N/A	\$13,198.68
General Counsel	\$15,062.26	N/A	115,500	N/A	\$15,062.26
Contracting / Procurement Agent	\$68,872.32	N/A	115,500	N/A	\$68,872.32
Subtotal	\$383,849.14				\$383,849.14
Contract					
Eligibility and Enrollment System	\$2,887,500.00	\$12.50	115,500	\$1,443,750.00	\$4,331,250.00
Call Center	\$25,569.72	\$1.00	115,500	\$115,063.74	\$140,633.46
Premium Billing Engine	\$112,500.00	\$1.46	115,500	\$168,750.00	\$281,250.00
Marketing	\$644,329.90	\$0.00	115,500	\$0.00	\$644,329.90
Navigator	\$201,570.75	\$0.00	115,500	\$0.00	\$201,570.75
Actuarial	\$233,020.30	\$0.00	115,500	\$0.00	\$233,020.30
Auditing	\$27,514.16	\$0.12	115,500	\$13,757.08	\$41,271.24
Legal and Other Prof. Consulting Services	\$102,894.68	\$4.01	115,500	\$463,026.06	\$565,920.74
IT and Website Design	\$487,500.00	\$2.11	115,500	\$243,750.00	\$731,250.00
Subtotal	\$4,722,399.51			\$2,448,096.88	\$7,170,496.39
Other Direct Expense					
Facility Cost (Plan Oper., Maint., Security)	\$0.00	\$0.00	115,500	\$0.00	\$0.00
Supplies	\$25,490.06	\$0.11	115,500	\$12,745.03	\$38,235.09
Subtotal	\$25,490.06			\$12,745.03	\$38,235.09
Total	\$5,131,738.71			\$2,460,841.91	\$7,592,580.62
Estimated HBE Population					115,500
PMPM for HBE Customers					\$5.48

Appendix A: Acronyms

Acronym	Stands For:
ACA	Patient Protection and Affordable Care Act
AV	actuarial value
CALT	Collaborative Application Lifecycle Tool
CCIO	Center for Consumer Information and Insurance Oversight
CMS	Centers for Medicare and Medicaid Services
DHSS	Department of Health and Social Services, State of Alaska
DOI	Division of Insurance, State of Alaska
EHB	essential health benefits
EIS	Eligibility Information System
ESI	employer-sponsored insurance
FAQ	frequently asked questions
FEHBP	Federal Employee Health Benefit Plan
FFE	federally facilitated exchange
FPL	federal poverty level
FQHC	federally qualified health center
FTE	fulltime equivalency
HHS	United States Department of Health and Human Services
IRS	Internal Revenue Service
IT	information technology
MAGI	modified adjusted gross income
M&O	maintenance and operation
PCG	Public Consulting Group
PMPM	per member per month
QHP	qualified health plan
RFI	Request for Information
RFP	Request for Proposals
SERFF	System for Electronic Rate and Form Filing
SHOP	Small Business Health Options Program
SNAP	Supplemental Nutrition Assistance Program
TANF	Temporary Assistance for Needy Families program

Appendix B: Actuarial Analysis

The Actuarial Analysis performed by Lewis and Ellis, Inc. is attached below. To open the document, double click on the icon



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Actuarial Report (Fin

